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VOLUME 44
NUMBER 7
MONTREAL
JULY
1948

GASTRO-ENTERITIS IN INFANTS

NURSING CARE IN HOSPITAL SERVICES
Marion Myers

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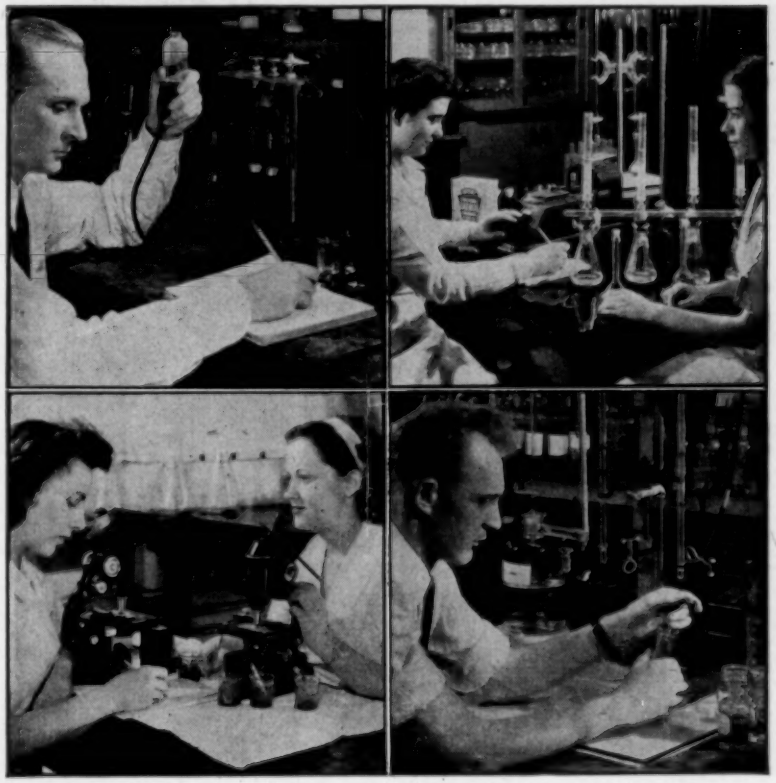

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

Subscription Rates: $3.00 per year — $5.00 for 2 years; Foreign & U.S.A., $3.50; Student Nurses, $2.00 per year — $5.00 for 3 years. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to *The Canadian Nurse*. (When remitting by cheque, add 15 cents for exchange.) *Change of Address:* Four weeks' advance notice, and the *old* address, as well as the *new*, are necessary for change of subscriber's address. Not responsible for *Journals* lost in the mails due to new address not being forwarded. PLEASE PRINT NAME AND ADDRESS. *Editorial Content:* News items must reach the *Journal* office before the 1st of month preceding publication. All published mss. destroyed after 3 months, unless asked for. *Official Directory:* Published in March, June, Sept. & Dec. issues.

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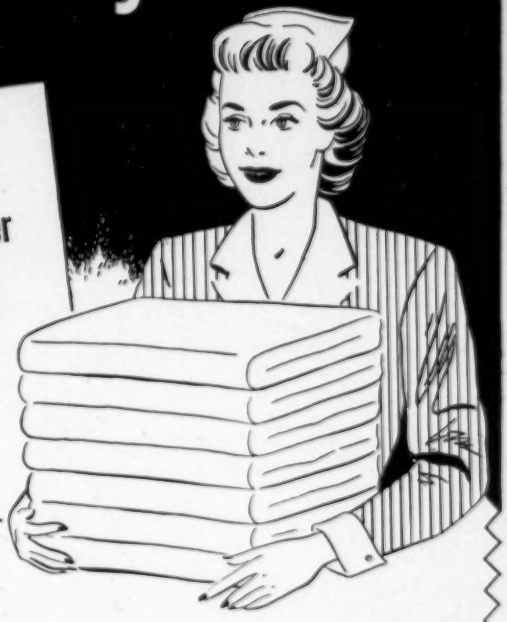

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Between Ourselves

A warm welcome goes to **Irene Maude Barton,** president of the Manitoba Association of Registered Nurses, who is our guest editor this month. Miss Barton, with becoming modesty, wrote us that the only very interesting thing about her past is that it has been a *long* one. "Most people think anyone who has graduated as long ago as 1913 should be dead or in a nursing home!" Proving the fallacy of this generalization, Miss Barton, who is a native of New Brunswick and graduated from the Moncton Hospital, takes a very active part in the nursing affairs of her adopted province — Manitoba.

Miss Barton served as assistant superintendent of nurses and operating-room supervisor at the J. H. Dunn Memorial Hospital in Bathurst, N.B., from her graduation until she enlisted with the Canadian Army Medical Corps in May, 1915. After eight months in England, Miss Barton went to France where she saw three years of service. For a goodly part of that time she supervised the fracture wards at Etaples. She was also operating-room nurse in various casualty clearing stations. In 1920, she was appointed superintendent and operating-room supervisor at the Galloway-Gibson Orthopedic Hospital in Winnipeg. Four years later, wanderlust seized her and for two years Miss Barton was superintendent of the American Hospital in Mexico City. Returning to Winnipeg in 1926, she joined the staff of Deer Lodge Hospital going, in the twenty years of her association with that institution, from staff nurse to matron. In 1946, she became the well-loved matron of the Veterans' Home and district matron with the Department of Veterans Affairs in Winnipeg.

In addition to her interest in provincial nursing affairs, Miss Barton participates in the activities of the Nursing Sisters' Association. She was national president of that group in 1942-44. She helped in various capacities in the Manitoba Division of the Canadian Red Cross Society, and was M.A.R.N. representative on the Local Council of Women.

Miss Barton is very fond of reading and music. She is interested in people, especially children. If she had more free time she "would like to help in kindergarten work, keep babies while mothers go shopping." Perhaps some day her dream of a "baby-sitter's" job will come true but not while she is the busy president in Manitoba.

Once again duplicate articles — this time a series — reached us from British Columbia and Nova Scotia. We have doubled up as much as possible because of the importance of the topic of **summer diarrhea in infants.** This disease ranks second as a cause of death during the first year of life. As improved sanitation, pasteurization of milk, and knowledge of how to handle these cases have increased, mortality has decreased. Nevertheless, from 1941-45, 1,622 infants were lost through this disease. This was an improvement over the five-year period from 1931-35 when 2,802 died but it indicated that there is *much work* still to be done.

Our ability to express ourselves clearly and precisely depends, of course, upon our education, knowledge, and experience. But the skill with which we form our syllables, the freedom from speech mannerisms, and the purity of tonal quality are all learned attributes. **Mme Mary B. Cardozo** describes the various forms of speech difficulties and, where possible, indicates how they may be prevented. Their cure is the problem of the speech clinician.

The activities of **nurses in industrial plants** have been a familiar picture for many years. A new angle on this form of service has been developed more recently with the co-operation of the Victorian Order of Nurses. Smaller plants which do not require the services of a nurse steadily are now able to provide an organized health program for their employees by buying service on a part-time basis from the Victorian Order in several communities. Miss Leleu describes how the program functions in Hamilton, Ont.

Are you enjoying the short feature known as **Chuckles P.R.N.?** If so, and you would like it continued, please send us the howlers that you have collected — our supply of them is running low.

The nurse occupies a much more vital and significant part in the whole structure of the healing professions than she has been given credit for.

— Dr. Patrick J. Maloney

- **46 YEARS OF "KNOW-HOW"...**
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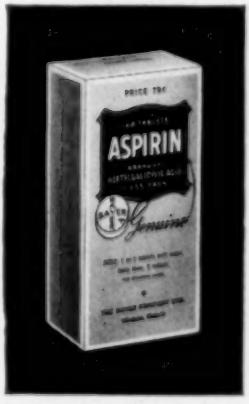

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REFERENCES:
(1) West. J. Surg. Obst. & Gyn., 51:150, 1943;
(2) Clin. Med. & Surg., 46:327, 1939;
(3) Am. J. Obst. & Gyn., 46:259, 1943;
(4) Am. J. Obst. & Gyn., 48:510, 1944.

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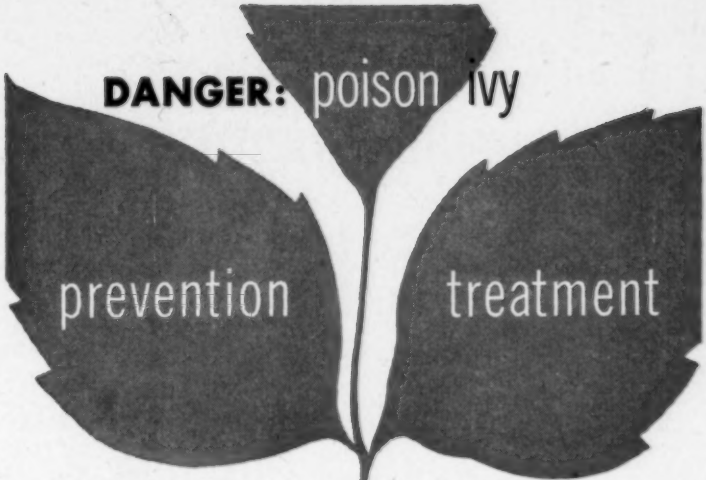

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New vitamin factors in canned foods

THE ROLE of the newer B complex vitamins in mammalian nutrition has been studied by a number of investigators in the last few years. Biotin, pyridoxine, and "folic acid" have been shown by animal experiment to be essential (1).

"Folic acid" has also been reported as effective in the treatment of sprue and certain other types of human anaemia (2, 3).

While the physiological properties and human requirements of these new vitamins are not fully understood or completely established, they will probably be elaborated in the near future.

In anticipation of that time attention is being directed to the occurrence of these factors in foods.

Tabulated below are the amounts of these nutrients found in representative canned foods (4).

It is planned in future work to develop more complete information regarding the biotin, pyridoxine and "folic acid" values of this important class of foods.

Pyridoxine, Biotin, and "Folic Acid" Contents of Canned Foods

(Recalculated in terms of four-ounce (113 grams) servings.)

		Pyridoxine	Biotin	"Folic Acid"	
				S. Lactis Factor	L. Casei Factor
Product	No. of Samples	Average Micrograms Per Serving	Average Micrograms Per Serving	Average Micrograms Per Serving	Average Micrograms Per Serving
Asparagus, Green	10	34	1.9	6.6	10.1
Beans, Green	11	36	1.5	3.3	8.7
Carrots	10	25	1.7	1.5	4.6
Corn, Yellow	10	77	2.5	1.9	6.3
Grapefruit Juice	11	16	0.3	0.6	1.4
Peaches	9	18	0.2	0.6	1.7
Peas	10	52	2.4	1.9	5.0
Salmon	10	147	11.1	2.9	7.8
Spinach	10	68	2.6	8.4	23.4
Tomatoes	10	80	2.0	3.0	6.1

(1) Nutrition Reviews *4*,163 (1946)
(2) Nutrition Reviews *4*,11 (1946)
(3) Am. J. Pub. Health *37*,688 (1947)
(4) Journal of Nutrition *31*,347 (1946)

This is one in a new series of articles which will summarize, for your convenience, the conclusions about canned foods, which authorities in nutritional research and canning technology have reached. Look for them each month in this publication.

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The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-FOUR *NUMBER SEVEN*

MONTREAL, JULY, 1948

Binoculars Lifted!

IN MEMORY, many nurses can recall the time when, upon graduation, the great majority of their classmates tripped down an alluring path into a garden of great adventure in private duty nursing. Only a small number could hope to secure employment in hospitals or with public health agencies. Staff vacancies in either rarely occurred except by marriage or death. The Brief, prepared by the Canadian Nurses' Association in 1947 for presentation to the Dominion Council of Health, showed clearly the changing picture that the years have brought.

	1930	*1943*
Nurses in private practice.....	6,370	6,327
Nurses in hospitals and public health work.....	4,160	13,959

These figures are particularly significant in making an assessment of nursing in Canada, or in any province of the Dominion, today. Certain implications are evident:

1. In 1930, nursing practice was, in the main, a private enterprise for 60 per cent of the registered nurses, compared to 31 per cent in 1943.

2. Social concepts of the use of nursing service have changed. In 1943, 69 per cent of the registered nurses were employed in public or private institutions, agencies, industries, etc., as compared to 40 per cent in 1930.

3. Nursing service has become a public utility needed by all and not just a luxury service for those financially able to pay for individual care.

Davidson, Winnipeg
IRENE BARTON

The impact of these points evokes the question: "If nursing services are now used so extensively in public, or group, or community enterprises, to what extent are nurses participating in the planning of these enterprises?" In applying this question to Manitoba, the answer was revealed in the reports given at the recent annual meeting of the Manitoba Association of Registered Nurses. Nurse representatives on the following councils and committees reported at that meeting.

The Hospital Council of Manitoba: This Council was established by the Minister of Health in 1945, to act in an advisory capacity to the Minister, to be responsible for the setting up of hospital areas and supervision of the establishment of hospitals in regard to standards of building, equipment, accounting, and service. Two members of the Manitoba Association of Registered Nurses have been on the Council since 1945.

The Special Committee to study the training of nurses and the supply of nursing personnel for rural hospitals: This committee was appointed by the Minister of Health to estimate the present and future needs for nursing personnel in the province and to make suggestions as to how those needs may be met. Four members of the M.A.R.N. acted on this special committee, one of whom represented the association thereon. The other three represented other official bodies with which they are associated in their work.

Advisory Council for Practical Nurses: Under "The Licensed Practical Nurses Act" (1945) this Council was established for the purpose of: (1) advising the Minister of Health in matters pursuant to the application of the Act and (2) executing duties assigned to it in the Act. In accordance with the Act, two members are appointed to represent the M.A.R.N. on the Council. In addition, according to the statute, the director of public health nursing, Provincial Department of Health and Public Welfare, is a member of the Advisory Council. Likewise, the Act requires that the registrar and consultant for practical nurses is a member of the Council and by the definition of the Act must be a registered nurse in good standing. In all, four members of the M.A.R.N. serve on this Council.

Advisory Committee on Nursing, Manitoba Division, Canadian Red Cross Society: Five members of the M.A.R.N. serve on this committee.

Joint Committee of the Manitoba Hospital Association and the Manitoba Association of Registered Nurses: This committee has been set up to study the possibilities of establishing affiliation experience in rural hospitals for selected student nurses. Four members of the M.A.R.N. are active on this committee.

National Council of Women, Winnipeg Branch: The M.A.R.N. is affiliated with this influential community organization and is represented at its meetings by a member who is appointed annually as the official representative of the association.

Council of Social Agencies of Greater Winnipeg: Affiliation with this Council provides the M.A.R.N. with information regarding social planning and action for the community welfare by the many agencies in the Council. It affords an avenue by which the association may extend its interests and efforts in community work in which nursing service is implicated.

Gone are the days of quiet, individual pursuit in nursing service. An aroused public consciousness is demanding the provision of those services which are essential to the health and welfare of mankind. In fulfilling society's expectations of the nursing profession today, the provincial associations of registered nurses and individual nurses must grasp (mentally and physically — with heart and hand) every opportunity to participate in the social planning for the betterment of humanity. Some so serve — but *all* sights must be focused on that planning. The M.A.R.N. is lifting its binoculars!

IRENE M. BARTON
President, Manitoba Association of Registered Nurses

Gastro-enteritis in Infants

REGINALD A. WILSON, M.D., M.R.C.P. (London)

THROUGH the ages mankind has been afflicted with a variety of plagues. The causes of most of these have been discovered and their dangers thus eliminated. There is one, however, which still takes a dreadful toll of human life. This is gastro-enteritis in infancy. Much is known regarding the nature of the disease and its rational treatment. In spite of this its control is admittedly imperfect and it remains one of the major contributors to our infant death rate, ranking second in the cause of death in infancy and childhood.

The present paper outlines some of our recent knowledge of this subject and emphasizes the role of the nurse in its control.

CLASSIFICATION

A. *Diarrhea of known etiology:* Originally a very large group of diarrheal diseases were classified together. Gradually the causes of some have been discovered and they have been classified separately, e.g.:

1. The dysenteries: These are caused by a variety of specific bacteria of the colon-dysentery group. In temperate climates the most common type is "Sonne Dysentery."

2. Parenteral infection: Non-specific (pyogenic) infections of other systems secondarily affect the infant bowel and cause diarrhea. Upper respiratory pathogens are the commonest offenders. Sometimes, however, they may be present in the role of secondary invaders and it is then difficult to determine if they are a cause of the disease or present as a result of the disease.

3. Food poisoning: Contamination of food by salmonella organisms or staphlococci produces toxins which will cause acute diarrhea and vomiting.

B. *Diarrhea of unknown etiology:* There remain two distinct clinical types of diarrheal disease of unknown etiology, viz.:

1. Epidemic diarrhea of the new-born: A disease of infants under three weeks of age which spreads in hospital nurseries.

2. Infantile gastro-enteritis: A disease of older infants which occurs sporadically and may spread in children's hospitals and homes.

For the purpose of this paper the latter two types will be considered together and are termed "gastro-enteritis of infants." Their symptomatology is identical, but it is claimed by some that cross-infection does not occur between the two types.

ETIOLOGY

Infantile gastro-enteritis is caused by an unidentified infectious agent. Various bacteria have been isolated but their causal relationship not finally proved. Virus etiology is also suspected but here again final proof is lacking.

PATHOLOGY

There are no characteristic pathologic findings. A slight congestion of the intestinal mucosa is usually present. Cloudy swelling and fatty infiltration of the liver are common. Middle ear infection and bronchopneumonia, present in some cases, are considered to be the result of secondary pyogenic infection.

EPIDEMIOLOGY

There are two common vectors: food and the institution.

Spread of infection by food has been decreased greatly by improved hygiene and sterilization of bottles and nipples. This has been largely responsible for the decline in the incidence of "summer diarrhea" in the home.

It is often stated the breast-fed babies rarely contract diarrhea and, if they do, only in a mild form. In a recent report of 221 cases, only

Dr. Wilson is a practising pediatrician in Vancouver, B.C.

three were breast-fed at the time of admission. There are numerous instances where adoption of universal breast feeding has stopped nursery epidemics.

However, sharp epidemic outbursts of this highly fatal disease still occur in nurseries and children's wards. There is an ever-present danger when infants are nursed in groups. Publicity given to outbreaks on brideships and in the understaffed postwar hospitals have highlighted this point.

Infants are highly susceptible and the disease will sometimes spread in spite of what appears to be careful aseptic technique. Although contact spread seems most likely, there is a possibility, if a virus etiology is postulated, that gastro-enteritis may be an air-borne infection. Certainly, respiratory infections which are frequently associated with gastro-enteritis are spread in this fashion. This fact has focused much attention recently upon the study of methods for control of the spread of infection in institutions. These can be classified as follows: isolation technique; oiling of linen; atmospheric disinfection by (a) Aerosols, (b) germicidal lights.

Studies by Weymuller *et al* have shown that careful adherences to a rigorous aseptic technique will prevent the spread of nursery infection. In fact, "isolation" is considered to be the single most reliable control measure. Unusual breaks in isolation technique may be overlooked. For example, according to Stern, a film may form on feeding bottles which persists after washing. This makes them resistant to sterilization by boiling. Use of pooled feeding bottles may thus spread disease. Resorting to spoon feeding or complete breast feeding stopped the epidemic in Stern's experience.

Dried excreta may contaminate bed-clothes and linen. Frequently infected dust particles are diffused by the handling of the linen. Oiling of the fabric diminishes this hazard. Recent trials of a new emulsifier for the oil (cetyltrimethyl ammonium bromide) has improved the process. This is considered by some to be an important new factor in the prevention of the spread of hospital infection. Of course, dry sweeping and dusting should be prohibited in children's wards.

Recently emphasis has been placed upon the role of the suspended droplet in the spread of institutional infection. The particles are called "droplet nuclei." Infected droplet nuclei may spread germs for great distances. Suspension of antiseptic agents in Aerosol form may prevent this aerial spread of disease.

Clinical Features

Characteristically, gastro-enteritis starts abruptly with loss of appetite and irritability followed by prostration and a slight fever. Diarrhea, with numerous watery, brown or greenish, foul stools, develops soon afterwards. Most cases have some vomiting. In the severe toxic form, vomiting and diarrhea are continuous and intractable.

The above combination of symptoms soon gives place to the secondary stage of the disease which is characterized by dehydration and acidosis. Now a dull, listless, pinched expression develops. The skin becomes loose and inelastic. There is a greyish pallor. The respirations become deep, the eyes sunken and glazed, and the lips red in color. A stage of circulatory collapse and death supervenes quickly if adequate treatment is not begun.

Treatment

Since there is no known specific antidote for the infection, the object of treatment is to preserve life by parenteral feeding until the infection burns itself out. After this stage of physiologic restitution and rest, the bowel inflammation may subside sufficiently to tolerate food by mouth.

The objectives in parenteral feeding are as follows:

1. The restitution of fluid loss.
2. The restoration of electrolytes. (Our body fluids are composed of solutions of essential salts termed electrolytes.)

3. The provision of calories to prevent starvation.

These objectives are accomplished, first, by the slow intravenous infusion of solutions containing sodium chloride and dextrose. Later, when the initial dehydration is overcome, 3.75% sodium bicarbonate or 1/10 molar sodium lactate are added to counteract acidosis. Finally, plasma is given to provide calories and restore blood volume.

In order to avoid the deleterious effects of over-correction of electrolyte imbalance, care must be taken to control the administration of these salts. The basal requirements for the infant of total fluid intake, calories, protein, and saline are calculated. The 24-hour total of infusions should not exceed these requirements once the initial deficits are made up.

Mention must also be made of the recent work of Darrow who emphasizes the importance of restoring loss of potassium. He proposes the use of an electrolyte solution containing potassium which may replace the use of other solutions in routine use.

Food by mouth may be withheld three or four days or longer, depending on the severity of the case. Plasma may be well tolerated by mouth at first; later protein milk is the food of choice. Vitamin intake must not be overlooked. Finally, other solid food, such as cereal, banana, cottage cheese, and gelatin, are gradually introduced as tolerated.

Mild cases, of course, will not require intravenous treatment. It may only be necessary to feed barley water or apple soup for twenty-four hours. Subcutaneous replacement of lost fluid may be sufficient in many cases.

Medicinal treatment with Kaolin and pectin or sulfonamides is frequently advocated. They are not a specific remedy, but may be helpful in controlling mild cases. Of course, sulfonamides are useful in the cases of true bacillary dysentery.

Nursing Care

Seriously ill babies require to be mothered as well as nursed. There is danger that treatment may become too mechanized. During the period of intravenous feeding the infant should be kept sufficiently mobile to facilitate the lifting required for adequate nursing care.

Skilful gastric lavage and rectal irrigation are important adjuncts in the management of distention and ileus, which are frequent complications. Sudden circulatory collapse is an ever-present danger. Nurses must be prepared for the emergency use of oxygen and coramine, or artificial respiration.

All nurses must realize the importance of contact spread of the infectious agent. Rigid aseptic technique must be preserved in the handling of food and disposal of excreta. The nurse must check her own health and report the development of minor symptoms.

Certain factors of nursery construction and administration must not be overlooked. Overcrowding is a serious danger. Thirty square feet per bassinet in nurseries is considered ideal. Understaffing is common and dangerous. The ratio of one nurse for eight to twelve infants in the new-born nursery is recommended. Formula preparation should be done in separate rooms and attendants must be thoroughly trained and supervised in the required technique. Autoclaving of the complete formula (seven pounds pressure for twenty minutes) in covered, nippled feeding bottles is advised.

Conclusion

The grave problem of infantile gastro-enteritis has been emphasized. The outlook, however, is not unhopeful. While the effect of sulfonamides and penicillin has been disappointing in this disease, there is hope that future research may prove the cause and provide an adequate remedy. Already knowledge of the epidemiology of the disease has decreased the morbidity appreciably. The use of improved isolation will reduce the dangers of institutional outbreaks. Meanwhile new techniques of replacement therapy by intravenous feeding have saved many infants which were previously doomed.

Gastro-enteritis in Infants

C. A. MacDonald, M.D.

THIS disease is also known as summer diarrhea; cholera infantum; epidemic diarrhea of infants, etc. It is a definite disease entity, as distinguished from celiac disease, the various specific forms of dysentery, ulcerative colitis, and those diseases in which diarrhea is a secondary manifestation.

Etiology

Infection must play a primary part, as indicated by the spread of this disease in a nursery, but to date no definite organism has been found to be solely responsible. Environmental factors, including hot weather, overcrowding, parenteral infections, particularly upper respiratory infections, of which middle ear disease is the commonest, and artificial feeding, with frequently faulty technique, are important predisposing factors. Diarrhea is more common in cities and factory towns where the sanitary and hygienic conditions are poorest.

The importance of diet is shown by the fact that the incidence of diarrhea is very much higher among artificially-fed babies than among the breast-fed. The entire stress cannot be laid on the bacteria in milk, although it is true that the bacterial count in raw milk is raised tremendously during the hot weather, particularly if it is not handled in hygienic manner. It is also believed that under the various environmental disadvantages named above, the gastric acidity is lessened, with an invasion of the upper intestinal tract, by organisms which are normal inhabitants of the lower bowel. It is also known, in diarrhea, that much of the carbohydrate undergoes fermentation, with the production of irritating fatty acids. Consequently, it is reasonable to conclude that infection plus diet are the important factors in the production of summer diarrhea.

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Symptoms

Clinically all degrees of severity are seen in infantile diarrhea, from mild cases to the severe forms with marked constitutional symptoms. In the milder forms there may be five to twelve stools per day. These stools are soft and watery, with a greenish-yellow color due to biliverdin, but the stool does not lose its fecal quality. Mucous and undigested fat curds may be present and the odor is foul, with an acid reaction. There may be a moderate fever, the child is irritable and fretful, with attacks of colicky pain. The appetite fails and there may be vomiting.

The more severe cases may develop from the milder type or may begin suddenly. The temperature may rise to 105° F. or more and there is marked prostration. The child is restless, twisting and turning constantly. It cries continuously and sleeps but little. The diarrhea may be delayed for several hours. The stools are large, frequent, and fluid. In the beginning they are fecal in character with an offensive odor and are brown, yellowish, or greenish. Bursts of flatus may be passed and the colicky pains may be quite severe. Later the stool loses its color and odor to a great extent and consists mostly of muco-serous intestinal secretions and may even become alkaline in reaction. Small evacuations may occur every few minutes. Vomiting accompanies or may even precede the diarrhea. It consists first of food, later bile, and finally a brownish fluid. The taking of food or drink may renew the vomiting. The child, who was at first restless, may lapse into a dull stupor or coma. There may be delirium, convulsions, or meningical symptoms. Due to the loss of fluid in the stool and vomitus, the appearance changes rapidly, because of the marked dehydration. Water and salts are lost in great quantities from the tissues. The skin loses its elasticity in a few hours, and a pinched-up fold returns only

slowly to its previous level on release. The eyes are sunken and lustreless; the fontanelles are depressed. The cheeks become ashen-grey and the tongue and mouth are dry. The weight loss is very rapid. The secretion of urine becomes scanty. Death usually results from circulatory failure. Due to the acidosis produced, air hunger, as evidenced by slow deep breathing (both costal and abdominal), occurs. The acidosis is due mainly to loss of base by the bowel, resulting in a disturbance of the acid-base equilibrium. Because of its run-down condition, the child affected with diarrhea is an easy prey to infections of all kinds and this infection is apt to delay the recovery from the diarrhea. The skin and subcutaneous tissue may become sclerodermatous — cold, rigid, and hard. Prolapse of the rectum is another complication which may persist for months. Severe forms of diarrhea are often followed by months of difficulty with the digestion. Excoriation, with sores over the buttocks, back, and heels, frequently occurs in prolonged cases.

Prognosis

Not only is the incidence much higher among artificially-fed babies than among breast-fed infants but the mortality is also much higher in the artificially-fed group. The prognosis is worse in the first six months than at a later age. It is difficult to obtain reliable statistics of the mortality due to diarrhea because it is often uncertain whether the diarrhea was the primary or a contributory cause of death.

Differential Diagnosis

To differentiate from other diseases with diarrhea, the stools of every case should be examined for bacteria, mucus, blood, and pus, to rule out the more specific forms of dysentery. Bacteriological examinations and agglutinations will distinguish chronic ulcerative colitis and tuberculous enteritis. The diagnosis of ulcerative colitis can be confirmed by proctoscopic examination. Tuberculous enteritis is generally associated with a tuberculous process elsewhere and Tubercle bacilli can be recovered from the stool. Typhoid and paratyphoid infections are associated with a splenomegaly and a positive Widal test. Celiac disease is characterized by alternating periods of constipation and diarrhea, with large pale offensive stools, and also by wasting of the buttocks and distention of the abdomen. It may also be differentiated from summer diarrhea by vitamin A curve estimations.

Prevention

Breast feeding during the first six months is the most effective single measure to prevent infantile diarrhea. If the baby is artificially fed, all feeding utensils should be regularly scalded and kept scrupulously clean; the milk should be pasteurized in a reputable dairy and the feedings should be boiled before use. If there is any doubt about the milk it is better to use evaporated milk. The infant should be protected from any infection and all attendants should wear a mask when handling the infant. The nursery should be cool and well-ventilated with the windows well-screened in the summer. If a case of diarrhea occurs in an institution the infant should be segregated and the nurse responsible for its care should not take part in the feeding or the care of other infants.

Specific Treatment

Diarrhea in breast-fed infants ordinarily does not present a serious problem. In mild cases it may be met by shortening the time of nursing, thereby reducing the food. If it is more severe alternating breast feedings with feedings of protein milk or boiled whole milk with cereal water may be effective. When the symptoms are overcome the infant may be returned entirely to breast feeding.

In the artificially-fed babies the treatment of diarrhea consists of: (1) appropriate treatment of any parenteral infection; (2) general treatment for shock, that is, warmth and a minimum amount of disturbance; (3) intravenous treatment. In mild cases a brief period of starvation for twelve

to twenty-four hours is effective during which 5% glucose in physiological saline may be given. If there is a tendency to vomit, begin with a teaspoonful, doubling the dose every half-hour until one ounce is given, then the interval may be increased to two hours. If this has been retained after twelve hours begin with small amounts of skimmed lactic-acid milk or protein milk. If breast milk can be obtained this should be used in preference to any other form of milk. The next stage is to add carbohydrate, starting with one teaspoonful per day, gradually increasing until the regular dietary schedule is attained. Calcium Caseinate (Casec) is sometimes added to the feeding because of its constipating effect.

If the diarrhea and vomiting are severe, parenteral administration of fluids must be given, subcutaneously or intravenously. Physiological saline or equal parts of this and 5% glucose may be injected under the skin in the axillae, chest, abdomen, or thighs. In this way 20 cc. of fluid per pound of baby weight can be given at one time. For repeated intravenous use, a cut-down on the long saphenous vein, anterior to the medial molleolus, using a gold needle, is the best method. A continuous drip method may thus be instituted, using 10% glucose-saline, or 5% glucose in half-strength physiological saline can be used, at the rate of 7 to 10 drops to the minute for twelve to twenty-four hours. Longer periods of continuous treatment may lead to edema. If the infant is severely shocked, avoid unnecessary manipulation. Blood transfusion is valuable later unless the hemoconcentration is too high, when plasma should be used.

Drugs play a minor part in the treatment of diarrhea although sulfaguanidine may be of some value, giving one grain of the drug per pound of body weight per day. In mild cases a bismuth mixture may be effective, such as bismuth hydrate in small repeated doses. Apple powder and apple pulp have been advocated by many in recent years, all other food being eliminated for twelve to twenty-four hours; one to two tablespoons of apple are given every two hours, after which there is a gradual return to the regular diet as it is tolerated.

To sum up the treatment, breast feeding and prevention are the most important features. The treatment, of course, depends on the degree of severity. The loss of fluid and base can best be replaced by intravenous administration of fluid as described.

Nursing Care of Gastro-enteritis in Infancy

MARY H. CANTY, B.A.Sc.

GASTRO-ENTERITIS has been a major nursing problem among the infant age group for many years. Various types of treatment may be ordered, all based on the necessity of combating acidosis, restoring fluid loss, and checking the diarrhea. To illustrate the hospital routine frequently followed, a typical patient has been chosen:

Mrs. Canty is clinical instructor at Infants' Hospital, Vancouver, B.C.

Murray, four months of age, was admitted to hospital on January 10. He was a pathetic sight — his eyes were sunken, his skin grey in color, loose and inelastic. His cry was weak and his respirations shallow and rapid. His buttocks were red and excoriated. The diagnosis was diarrhea and vomiting.

Emergency treatment was indicated. He was placed in an oxygen tent to improve his respirations and to help prevent the painful abdominal distention. Coramine, for cardiac stimulation, was given immediately.

His history revealed the typical symptoms

of loose stools for thirty-six hours, becoming more severe with a slight temperature rise and irritability. The stools were described as loose and watery, greenish-brown in color, with a foul odor. Barley water had been tried with no results and, when the baby began to vomit, the doctor advised hospitalization.

The past history of the child was uneventful and seemed normal. Murray was an only child, breast fed for six weeks, then placed on an evaporated milk and Karo syrup formula. The family history was essentially negative.

Fluids to combat acidosis were necessary. A subcutaneous injection of normal saline, warmed to body heat, was given. The administration of fluid interstitially is restricted to the tolerance of the baby's tissues and general condition. The site chosen for this injection was the scapular region. In spite of gentle massage to aid in the absorption of the fluid, only 60 cc. were taken. It was necessary to prepare the child for intravenous administration of fluids.

The laboratory technician took 1 cc. of non-oxalated blood for the Red Cross Blood Donor Service, to be crossed and grouped for immediate transfusion. At the same time 0.2 cc. of oxalated blood was collected for a complete blood count.

The intravenous cut-down was done on the right ankle. The child's leg was first bandaged to a padded splint. The houseman made a small incision on the inner right ankle and inserted a gold cannula into one of the tiny veins. Since the baby was very dehydrated, isotonic saline was first dripped in slowly, before the administration of the blood. Murray was then taken back to his crib, put into the oxygen tent, with the intravenous flask tied above the foot of the crib.

After 100 cc. of normal saline had been given, 70 cc. of whole blood — 7 cc. for each pound of body weight — were dripped in. Then the intravenous was continued with normal saline. Murray was closely watched for transfusion reaction, but displayed no untoward symptoms.

In order to keep the needle in the vein, a sterile gauze dressing and bandages were used to hold the leg and splint to the crib bars for immobility. The other leg was also lightly but securely restrained to prevent excess kicking. Elevation of the leg into which the intravenous was running aided circulation and helped to prevent edema of the limb.

Murray had now been hospitalized for about four hours and was showing slight improvement in color and tissue turgor. His stools were watery-green and very frequent, occurring about every half hour. Rectal temperature taking was restricted to every four hours, as it often aggravates the already irritated rectum.

Immobility was a great problem. It is important that a child have sufficient movement and exercise but, because of the restraint, obvious difficulties were presented. At least every two hours the baby was changed and the untreated leg moved about.

No specific organism was isolated from Murray's stool specimens but, because of the epidemiology of his condition, all isolation precautions were taken. This included disinfection of excreta, with a 2% lysol solution, and sterilization of used linen. Careful washing of hands was stressed continually for protection of other infants and of the staff. The daily nursing care included sponge bathing and special care to his buttocks, to which buttocks paste was applied. Boroglyceride solution was painted to lips and gums to prevent cracking, particularly during the time spent in the oxygen tent.

The intravenous was continued for four days. The saline was alternated with 5% glucose and saline. Glucose water by mouth was given every four hours, in quantities up to four ounces. On the second day apple soup was started. This is given for diarrhea and is made as follows: grated raw apple pulp, 12 oz., normal saline, 12 oz.; freshly brewed tea, 6 oz., saccharine (½ gr.), 4 tablets.

The apples are grated and the pulp put through a fine sieve. The other ingredients are then added to this pulp. The pectin in the apple serves to absorb the toxins in the bowel, and the tannin of the tea has an astringent action on the mucous membrane of the bowel.

Murray's stools became less frequent and the fluids by mouth were retained after the initial acidosis was overcome. On the fourth afternoon the intravenous was discontinued and he was started with lactic acid milk formula, made by culture method. Since the small amount of two ounces every three hours was taken well and retained, the formula was gradually increased during the next week from a fat free milk to a 2% milk, and to six ounces, with six feedings a day.

The leg into which the intravenous had run was very tender so the general activity of the child was stimulated by picking him up for feedings and changing. The stitches from the cut-down incision were removed on the

seventh day and a tincture of zephiran dressing applied.

Vitamin concentrates were started on the tenth day when Oleopercomorphum, minims 6, and ascorbic acid, 50 mgm. daily, were given.

The stools had become firmer and less frequent. Murray was retaining his feedings and wanting more. On the fourteenth day his formula was changed to boiled whole milk and water with Dextri-Maltose No. 1. During the next two weeks Pablum and vegetables were added to his diet and orange juice substituted for the ascorbic acid tablets.

Affection is a necessary nursing measure, especially following the completion of intravenous therapy. Murray was a lovable child and had enjoyed much attention at home, so responded well to our loving. Brightly painted toys, tied to his crib, helped to attract his attention.

His mother was intelligent and accepted well the health teaching given her before Murray's discharge. She was given instructions about his diet and formula, the necessity for frequent medical check-ups, and the location of the nearest well-baby clinic.

On his twenty-eighth day, Murray left the hospital a little pale but certainly a different child.

The important nursing points in institutional care of gastro-enteritis are a realization that, as it may be communicable to other infants as well as to the nurse, proper isolation precautions must be taken. For the infant, the restoration of body fluids and the development of his tolerance to his dietary needs are vital. Patience and skill are necessary in carrying out the many procedures required for the treatment during the acute illness and convalescent stages of this condition.

Public Health Aspects of Gastro-enteritis in Infancy

JENNIE HOCKING

To prevent and control disease it is necessary to make use of all available knowledge regarding: the causative agents; methods of transmission.

As has been pointed out, the causative agents of gastro-enteritis can be divided into two groups — those of known etiology and those of unknown etiology. In both groups the disease may be spread in a number of ways. It is believed that the most common method of transmission is through the mouth — by food or objects which have been contaminated by the causative agent. In the group with the unknown etiology, the virus theory also gives rise to the possibility of droplet infection from the air. Preventive measures, therefore, must aim at protecting food and objects, which may come in contact with the child's mouth, from contamination and his surroundings from possible air-borne infection.

Miss Hocking is on the staff of the Metropolitan Health Committee, Vancouver, B.C.

CARE AND PREVENTION

The public health nurse at every opportunity in her contacts with the community should teach that anyone developing abdominal cramps, diarrhea, vomiting, and fever may be suffering from infectious diarrhea, particularly if other members in the household are affected at the same time, and that a physician should be called. Where these symptoms occur, precautions should be taken from the outset and a note made of any suspicious food or circumstances which may be connected with the cause. Most cases of infectious diarrhea develop within twenty-four hours after infection has entered the body, usually within twelve hours. Because infants are extremely susceptible they

must be protected in every way possible and extra precautions taken where there are babies in the home. In order to make her teaching effective the public health nurse must give instructions which are simple and easy to carry out. The following instructions were drawn up by the epidemiology department of the Metropolitan Health Committee of Vancouver:

General hygiene (where there is a case of infectious diarrhea):

1. Absolute cleanliness is essential.

2. After using the toilet wash hands thoroughly with soap and water. Use your own towel.

3. Do not handle food, drink, eating utensils or dishes to be used by others. At table handle only your own food, and your dishes should be placed in boiling water after use. Any food which you leave after a meal should be discarded.

4. Every bowel movement not passed into a toilet connected with a public sewer should be disinfected. If the toilet connects with a septic tank disinfect bowel discharges in a separate container and bury them. Disinfectants may interfere with the normal operation of a septic tank. Use your own roll of toilet paper.

5. Your urine should be disinfected by the same method adopted for the bowel movements. Never urinate upon the ground.

6. Soiled linen, diapers, underwear, bedsheets, etc., should be disinfected before laundering.

7. Notify your physician if other members of the family are ill.

8. Do not change your address without permission of the medical health officer.

9. No one suffering from or a carrier of infectious diarrhea should handle or prepare milk or perishable food intended for consumption by other people.

Disinfection procedures:

1. Bowel movements and urine should be passed into a covered receptacle. Cover contents with one of the following and leave for one hour:

(a) Carbolic acid solution 5% — 7 oz. carbolic acid to 1 gal. water. (The addition of a ½ cup of salt hastens the disinfecting action.)

(b) Formaldehyde solution 10% — 13 oz. formalin to 1 gal. water.

(c) Chlorinated lime 3% — 3 oz. chlorinated lime to 1 gal. water.

Disposal should be made by burying the contents deeply in the ground, well away from open ditches or wells. After this is done the receptacles should be washed thoroughly with disinfecting solution before use.

2. *Disinfection solutions:* Carbolic acid solution — 2½% — 3½ oz.— 1 gal. water or creosol, lysol, creolin, cycol 1% — 1½ oz.— 1 gal. water. Disinfection solutions may be used for: (a) bed pans, receptacles, bath-tubs, etc.; (b) diapers, soiled linen, underclothing, and cloths. It is convenient to have a large covered pail with the necessary amount of solution in it for this purpose. Place the materials in the solution, stir, leave for one hour, clean and rinse, then wash thoroughly in hot soapy water.

If your toilet does not connect with a public sewer the disinfection solution after use should be buried in the ground.

Avoid placing your hands in these solutions. Transfer materials with forks or sticks which are kept in fresh solutions after use.

Remember that these disinfectants are poisonous if swallowed. Make sure that they are properly labelled and placed out of the reach of young children. (There are other disinfectants available which are quite satisfactory if instructions on the labels are carefully followed.)

Prevention — for everybody: Infectious diarrhea may be spread: from person to person, through unclean habits; from infected foods (animals and fowl), milk and water; from insects and rodents and through dust.

Care of foods: Keep food *clean, cool, covered.* Refrigeration is safest and best. Meats, fowl, eggs should all be thoroughly cooked before use. Care must be taken in evisceration of fowl to prevent contamination of other foods and utensils. After cleaning make sure that organs, etc., are immediately wrapped and properly disposed of. Wash down the block or table with disinfecting solution and clean hands thoroughly. Do not handle other things, especially food, while cleaning fowl.

Do not handle food if you have boils or running sores on the hands, wrists, or forearms.

Do not sneeze or cough over food, and after blowing the nose wash hands thoroughly before handling food.

Fresh vegetables and fruit for salads and for eating raw should be thoroughly washed before use.

Perishable foods, meats, milk, milk pro-

ducts, custards, dressings, and pastries should be kept refrigerated. Cream-filled pastries and meat pies should be eaten on the day of preparation.

Never eat oysters or other shell-fish, in a raw state, from polluted water.

Never bathe in areas polluted by sewage.

Use only pasteurized milk. Milk given to babies under one year should be boiled.

Doors and windows should be screened to keep out flies and insects. Eliminate flies within the house.

Judicious baiting and trapping will help to control rodents.

Keep food covered.

Keep garbage wrapped and place in a covered container.

When water supplies are unsafe boil or chlorinate drinking water before use.

All water given to a baby under one year should be boiled.

Make sure that house plumbing is in good working order. If house plumbing is faulty or the water pressure low, with a possibility of siphonage from plumbing fixtures, have these faults corrected. Boil drinking water before use until defects are remedied.

Extra care must be taken when babies are present in the home. They are extremely susceptible to infectious diarrhea and must be protected at all costs.

Prevention in the Care of the Infant

The incidence of gastro-enteritis is always much less among breast-fed babies. The public health nurse in her contacts with expectant mothers should stress in every way possible the value of breast feeding, and point out how it minimizes the danger of infection to infants. Two reasons probably play a big role here — breast milk gives the child a greater natural resistance to infection and the dangers of contamination are slight compared to those of artificial feeding from a bottle.

During the prenatal period, the public health nurse has a splendid opportunity, through home visits and group talks, to encourage mothers to want to feed their babies. She can teach in advance the simple precautions needed to make infant feeding safe. These include:

1. The thorough washing of the mother's hands before handling her breasts or the infant.

2. Washing the nipples with clean pledgets and solution.

3. Scrupulous cleanliness of brassieres and garments worn over the breasts.

4. Give water and later orange juice from a freshly sterilized cup and spoon, rather than from a bottle.

5. All water given to infants under one year should be boiled.

After the baby is born the nurse should encourage the mother to continue breast feeding and instruct her in the best ways of maintaining her supply of milk.

Where the infant is not entirely breast-fed, the public health nurse should endeavor to supervise the preparation of the formula or make sure that the mother understands the best methods of doing this. These instructions should include:

1. Proper cleansing and sterilizing of nipples and bottles and articles used in preparation of formula.

2. Proper method of preparing the formula.

3. How to keep food, bottles, etc., free from contamination between preparation and feeding time. Protection from dust, flies, and other insects.

4. Refrigeration is the best method for preserving milk and other perishable foods. Where this is not possible instruct the mother in the best alternative methods of keeping foods cool and clean.

5. Pasteurized milk should be used wherever it is available.

6. *All* milk for infants under one year should be boiled.

In addition to the care of the food given to the baby, the family should be instructed to protect the infant from other sources of infection. This teaching should include the following:

1. Do not allow anyone who is not perfectly well to handle or come in close proximity to the infant.

2. If the mother or baby's attendant develops a cold or other infection, covering the nose and mouth with a clean mask while attending to the infant will help to minimize the dangers of passing the infection to the baby.

3. During the day-time the infant should sleep out of doors, protected against flies and other insects, as much as weather and circumstances will permit. At other times he

should sleep in a well-ventilated room.

4. Care should be taken when cleaning and dusting, particularly where dust is raised, that the infant is not in the room.

5. Doors and windows and, where necessary, the infant's bed should be screened against flies and insects.

6. The young infant's clothing, towels, and bedding, etc., should always be kept and washed separately from the household clothing.

Correct feeding and general good hygiene maintained at all times will help to keep the infant well, lessen chances of infection, and build up a better resistance to illness should it occur.

Parents should be taught to call a physician if symptoms of diarrhea develop, and that frequent drinks of boiled water and barley water may be given instead of the regular feedings, until the doctor is contacted.

During illness the public health nurse can assist the mother to carry out the physician's instructions regarding treatment and, when ready, the gradual resumption of regular food.

SUMMARY

Because of its contagious nature, the public health nurse can play an important part outside the hospital in helping to control the spread of gastro-enteritis in infants, when there is any incidence of the disease. Her greatest role, however, should be that of a continual teacher of those health practices outlined above, with special emphasis on breast feeding, which will minimize the likelihood of infants being exposed to this infection.

Speech Problems of the Growing Child

MARY B. CARDOZO

NINETY PER CENT of all our communication is oral. By the increased use of the radio, cinema, and telephone, we are becoming more "speech conscious." If we are sincere in our educational efforts to develop the child as a whole, then we must give more attention to the development of better speech for the normal child, as well as encouragement and assistance to the child with defective speech.

Deviations from standard speech must be limited if we are to carry on an effective and truly child-centred educational program. The individual with a speech disorder, even a minor defect, is handicapped in most vocational, social, and educational activities. Moreover, the person so handicapped is likely to feel inadequate as a result of his obvious problem. Investigations indicate that a serious speech or hearing disorder usually entails a personality maladjustment. Conversely, once the disorder is corrected or modified with speech training or a hearing aid, and with mental hygiene, the maladjustment is largely solved.

Speech and hearing handicaps should be discovered and treated at the earliest possible age. The longer they are allowed to persist, the greater the danger that serious and compelling problems of adjustment will develop, and the more difficult the correction becomes. The majority of children with speech and hearing deficiencies are potentially normal if the defect is detected early enough. The large proportion of disorders or defects usually appear because of early speech mal-development. Frequently parents, teachers, and doctors believe the child will "outgrow" the speech problem,

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and consequently it is ignored. If he does outgrow it, he is the exception to the rule, which is attested by surveys in elementary and high schools and colleges. There are at present in the United States 2,800,000 speech defectives in attendance at clinics.

Not only do speech difficulties require more time to correct, but the older the child becomes, the more opportunity he has had to develop unwholesome attitudes. We can render a real service to the child by referring him for early investigation, and by presentation of a re-educational program where indicated. By the time the child is ready for school, he should have an equal opportunity for progress and happiness.

Let us limit this discussion to those problems which nurses may find in the course of their work. The organic disorders such as cleft palate, the birth injury, and other medical conditions invariably receive clinical treatment. We will confine ourselves to the less discernible, the less dramatic, the kind of minor problems which the doctors often say the child will "grow out of." Because it has gone unheeded we find, even at the university level, uncontrolled stuttering with an accumulation of poor attitudes, defective articulation, poor voice use, lisps, foreign accents, and local substandard dialects.

Just as a headache is usually regarded as a symptom of an underlying disorder, so a speech problem, however slight, must be regarded as a symptom which needs thorough investigation. For purpose of clarity, defective speech may be classified into three major categories: disorders of articulation; disorders of voice; disorders of speech rhythm. Briefly, some of the factors which make for normal speech are: (a) audibility, which means volume; (b) precision, which refers to articulation, the actual making of sounds, the mechanical process; (c) pleasantness, good voice quality; (d) logical content which is dependent upon a knowledge of language. When one or more of these factors is distorted, then we may say the speech is defective.

Articulation

These disorders are marked by the omission, substitution, addition, or distortion of certain sounds. The "s," the "l," and the "r" seem to be the sounds giving the most trouble. According to studies, these sounds are learned last, and are mechanically and acoustically difficult. If any or all of these sounds are not learned by the time a child is ready for school, then we say he is defective, and will remain so unless help is given. An average child, by the time he is three years old, should *know* all the sounds of English. A child of three-and-a-half years should have all the sounds of English *mastered*. Between five and six he should be talking intelligibly, without difficulty of any sort. Of course, some children do not follow this pattern for various reasons, but statistical averages show that these are the ages when sounds appear and are mastered.

All difficulties of the "l" and "r" are termed "lalling," and occur perhaps less frequently than the "s" or lisping. Since "s" occurs in 80 per cent of the words we use, one can see how distorted lispers' speech can be, and how important the correction of this sound is for general smoothness. To make this sound perfectly, we need muscular precision, hearing acuity, good muscle tonus, and good dentition. These are all necessary mechanical factors, but very often we can regard certain variations of lisping as symptoms of personality maladjustment. The etiology of many baby talkers can often be traced to parental difficulties, as can many speech problems.

When dealing with articulatory problems as symptoms, we must consider first of all certain physical aspects, the most important of which is hearing. Defective hearing, especially diminished regional acuity in certain ranges, is responsible for lack of perception and, therefore, responsible for lack of reproduction of certain sounds. Because of partial perception losses in certain areas, these sounds will not be accurately reproduced, for one cannot reproduce what one

cannot hear. The most conservative estimate, based on numerous surveys, shows that about 1.5 per cent of the total child population have such serious hearing losses as to be significantly handicapped in oral communication, and in need of lip reading and speech education.

Parents and teachers must be alert to the usual physical and psychological symptoms of diminished acuity. The latter symptoms are inattentiveness, shyness, and uncommunicativeness. Too often children are referred to clinics as behavior problems, when they are actually hearing problems. Some communities are so awakened to the importance of detecting hearing loss among their school population, that they require by law the administration of periodic audiometric examinations along with the regular physical examination. Those children showing any loss or questionable results are directed to the otologist for further examination and testing, with recommendations for mechanical hearing aids where necessary. They then go back to the classroom equipped to compete with the other children on a more equal basis.

Other causes of faulty articulation as well as defective use of voice and rhythm, of course, could be psychological. For example, let us examine the child who lisps. Probably he lisps because he has not learned to pronounce the "s" sound correctly; or perhaps his mother has a foreign accent and he has a poor model at home. Maybe he is lacking in adequate muscular tonicity; or he wishes to remain younger than his brother. The latter is decidedly a psychological factor, and in this case a mental hygiene program for the parent, as well as the child, would be in order.

A thorough investigation of even the slightest speech deviation should be made. Some of the local conditions causing faulty articulation might be congenital or acquired defects of the tongue, lips, teeth, palate, nose and larynx. The factor of mental growth stands in high correlation with general language ability. The children who are backward mentally naturally take a longer time to learn to make difficult sounds, and their speech development is normally later than that of the more gifted. Another factor may be faulty training, that is, careless or foreign patterns of speech in the home. The need here is for good speech models by both parents and teachers.

Voice

These disorders are recognized because they do not conform to standards of volume, pitch, and quality. Does the child speak too loudly or too softly? Is his pitch natural for his age and sex? Does he modulate his voice to enhance meaning or does he adhere to a monotone? Is his vocal quality harsh, nasal, or hoarse? Does his voice sound as if he had a head cold? About 24 per cent of the speech problems are related to vocal variations.

The voice reflects the general physical and mental health. The attitudes of the person speaking can also be regarded as an accurate index of his physical and mental health. It is always the sum total of the health and status of the individual at that particular time, plus his previous experiences. Any unusual change in quality, intensity, tempo, loudness, etc., must be regarded as a symptom of some underlying problem, be it organic or psychological. A few of these disorders may begin with organic symptoms, but they would account for only about 15 per cent of all the cases. The majority seem to be functional, and often the result of a continued misuse of the voice. The qualities which are necessary for good voice use include such things as: good models to imitate; freedom from undue tension in the environment; voice consciousness—that is, learning to listen and becoming aware of the feel of smooth, well-supported tone. Too often this important aspect of speech is forgotten in the deluge of subjects that we are attempting to teach.

Since voice is one of the most sensitive indices of mental health, and as misuse of any part of the body cannot continue without doing that particular part a good deal of harm, the best

therapy in this case is prevention. Parents and teachers of children who show a tendency to be hoarse, or dysphonic, should be informed of the possible consequences of continued screaming and shrieking. The tense, strident, aspirate voice, a symptom of underlying tension, serves too often as a model for our children. If this misuse of the voice is allowed to continue, it will sooner or later result in an organic pathology, since the majority of vocal cords cannot stand so much abuse, and certain types of voices need protection. An organic condition may develop in addition to the original psychological problem.

Another cause of poor voice is association with an individual whose voice is defective. Most children tend to imitate the mannerisms of individuals for whom they have admiration, affection, and hero worship. Unfortunately, the child may adopt any disability present. General hypertension often causes constriction of the phonating mechanism. The laryngeal valve is one of the first structures of the body to reveal general tenseness. This is shown in emotional states of fear, excitement, and rage. Readiness for emergency demands holding the breath with a firm closure of the vocal bands. All this produces symptoms of defective pitch, intensity, and quality. The usual cause seems to be insecurity and fear of inadequacy, due to environment. Emotional maladjustment with its personal problems, and the history of profound emotional conflict, interferes with voice production. The phonating aspect of speech reflects the attitude, the general health, and mental and physical state of the person speaking.

One can see here the depth of the problem of voice disorders, and understand the need for investigation by the psychologist and speech clinician. The disorders mentioned are the most common and general. The treatment of the symptom is essential, but voice disorders absolutely require, as do all speech problems, the removal of the etiological factors. To summarize, the requirements which provide for good models of voice are: freedom from undue tension in the home and school; easy production of tone; voice consciousness; discouragement of the necessity for yelling and screaming.

Rhythm

Stuttering is manifested by about 1 per cent of the population. It is undoubtedly the most complex of all speech problems, and certainly the most propagandized. There are at least fifteen current theories on the cause of stuttering but, whatever the cause, it is important that the parents of children who show these symptoms receive some intelligent advice with suggestions for proper co-operation in forming correct attitudes. Treatments must cover the speech mechanism as well as the personality problems which have resulted from this condition. Most personality changes which accompany this lack of fluency are only a result of the defect, and not a primary cause.

It would be confusing to attempt to outline the various theories regarding causes of stuttering, and just as confusing to attempt defining exactly what stuttering is. Stutterers do not always stutter in the same way. These cases fear speech; they all expect to have difficulty; they make hard work of speech and they think they are different from normal speakers. In addition to this, their attitudes, beliefs, and opinions of themselves seem to be at fault. In the early stages of speech, one is almost certain to hear a great deal of repeating, pausing, and prolonging, especially if the child feels that he must hurry or must try to speak very well.

The study made by the Rockefeller Foundation on the onset of stuttering tells us a great deal. This study indicates that very young children, learning to talk, repeat 25 per cent of their words—perhaps the initial sound, or the whole word, or part of the word. The average child, learning to talk, repeats forty-five times per hundred words. In addition, there are frequent hesitations and pauses accompanying this type of repetition. This must be considered normal rather than abnormal. The danger lies in drawing

attention to them at this particular time.

When children have difficulty with speech, they are not helped by being labelled as stutterers by such directions as "take your time," "stop and think what you are going to say," "take a breath and begin again." Some children are naturally going to be a great deal more fluent than others, and we must regard this as a natural difference. The most important consideration is that they do not become unduly concerned or alarmed about their speech and associate the speech situation with a tension-producing situation. After all, it takes a few years to acquire the skills necessary for smooth speech and for the handling of conversation. When undue attention is drawn to the child's speech attempts, in addition to the known lack of fluency, we have feelings of shame and guilt resulting from scoldings, naggings, and parental disapprovals. These create negative evaluations on the part of the children regarding their own ability to speak. As an illustration, a study was made among the Indians. It was found that no Indian stuttered, and that they had no word for it. It was found that the Indians' standards of child care seemed to be extraordinarily lax in comparison with our own. Every Indian child was regarded as a normal speaker, and thus had no speech anxiety or frustrations.

Early stuttering is very different from stuttering in the adult stage. As the non-fluent child becomes more conscious of differences, his manner of speech becomes more hesitant, more cautious and labored. In this way, normal speech hesitations and pauses become formed into the exaggerated frustrated symptom of the adult stutterer, who develops secondary symptoms to disguise the original natural pauses and repetitions. At one time it was thought that lack of cerebral dominance was the cause of this symptom, but studies show this to be erroneous. It is true that unilateral dominance is more favorable for motor development, but recent studies show that only one stutterer in ten will show the symptom of mixed dominance.

In New Jersey recently, a study was made of left-handed children in the elementary schools, covering a period of four years. All left-handed children were made to use their right hands, and not one case of stuttering was produced. I do not recommend this as a form of procedure, but it is an example of one study showing that the old theory has lost its weight.

Some experts suggest children should not be required to perform in programs which are obviously difficult for them. Little speeches and recitations can be deferred until the child is old enough and mature enough to handle them. This does not mean that a child who is less fluent should be excused because of his speech, but it does mean that he need not be forced to attempt performances beyond his development.

In making any direct attack on children's speech problems, there are a number of suggestions which might be followed by those who have to do with stuttering or less fluent children. All of these suggestions are indirect, but may be a help. What is needed is a relativistic approach with the realization that individuals exhibit great variation in fluency within normal limits. Help all children to speak by supplying indirect encouragement in easy situations, and give equally indirect encouragement in difficult situations. Treat all speech, good or bad, with complete lack of anxiety. Set a good example yourself using unhurried, effortless speech. Encourage them to carry their share of conversations and schoolroom recitations.

The stuttering child should be treated as any other child. Never let him think that he must stutter or he always will. Give him sufficient responsibility so that he has some feeling of independence. Give sufficient time for all speech attempts. Do not encourage the development of mechanisms such as finger-waving, lip-moving, or foot-stamping for the purpose of increasing smoothness of speech. These are distractability techniques which seem to make speech easier,

but become secondary symptoms when allowed to continue. Once the child feels that he is a stutterer all the obvious aspects of stuttering begin to develop rapidly. When he begins to strain, force, and struggle with his speech, then stuttering has developed. Once this behavior is established, speech clinic treatment is certainly indicated.

The final thought that I want to leave is that defective speech can be prevented to some extent. Nurses, doctors, teachers, and parents should bear in mind the need for keeping in close touch with specialists in this field, and to try to follow their recommendations and suggestions which, when properly applied, should prove of great benefit to these children.

Cellophane Wrapping of the Thoracic Aortic Aneurysm

SISTER MARY CLAIRE, S.S.A.

THE unusual procedure known as Cellophane Wrapping is indicated in cases of aortic aneurysm. The progressive and fatal nature of this lesion makes the treatment urgent and very important.

The purpose of this procedure is to stimulate the growth of a new wall around the weakened aorta. Reactive Cellophane is an intense tissue stimulant and causes marked overgrowth of fibrous connective tissue. By this means, therefore, a thick fibrous tissue wall can be built up around the aneurysm.

In applying this wrapping, the thorax is opened widely and the ribs retracted with a rib spreader. The aneurysm is thoroughly exposed and one layer of this special Reactive Cellophane is loosely placed around the entire circumference of the aneurysm. Because of its intense reactivity, it must be completely isolated from the pleural cavity. Therefore, if the mediastinal pleura cannot be completely closed over it, a pleural or pericardial graft must be used to complete the closure. The thoracic wound is closed tightly around a catheter.

The pre-operative preparation is very similar to that of any major operation. The red blood count and hemoglobin are carefully checked a few days previously, as well as on the morning of operation, and blood transfusions given as indicated. Plenty of blood should be on hand to meet any serious complication, such as rupture of the aneurysm, which might occur during the operation.

The post-operative care is the same as in any serious operative procedure with emphasis on the following:

The patient is placed in low Fowler's position in an oxygen tent for the first forty-four to forty-eight hours. Mild continuous suction is attached to the in-dwelling tube by means of a Wangensteen's apparatus; this is continued for forty-eight hours. Usually, the patient gets out of bed on the night of operation and is allowed to walk around the room.

Mild sedation only is used and this may be intravenous alcohol or small doses of demerol. The reason for not giving heavy doses is that it is important to maintain the ability to cough. Blood transfusion is again given if necessary. When indicated penicillin may be given for several days. On the first post-operative day a full diet is allowed if tolerated by the patient. The pulse should be watched carefully and if it becomes less than sixty per minute, atropine gr. 1/100 should be given immediately.

From the above outline of nursing it is quite obvious that special nurses are required for the first few days.

Sister Mary Claire is chief instructor at St. Joseph's School of Nursing, Victoria, B.C.

Dietary Services in Hospitals

GRACE A. TORRIE, B.Sc., H.Ec.

DIETETICS is generally considered to be a relatively new profession, though the habit of eating is not a product of the "Atom Bomb Age," and dietetics is primarily concerned with this habit. It is the feeding of people "in sickness and in health" that is its basis.

Since the beginning of the practice of medicine, food has been recognized as having an important part in the treatment of disease and, from its beginning, organized nursing service has realized the patient's need for "nourishing" food and the nurse's need for "instruction in cooking." To complete the picture, we have the hospital administrator vitally concerned with the cost of running the food department, because about 20-25 per cent of the hospital's total budget is invested here.

The services of the Dietary Department may be classified generally as being twofold. We have on one hand responsibilities chiefly scientific and concerned with normal nutrition and diet therapy; and, on the other, responsibilities chiefly managerial and concerned with the food administration for all patients and staff; the departmental budget, and the departmental personnel. In larger hospitals these duties are fairly well specialized and we have our therapeutic dietitians and our administrative dietitians.

The responsibilities of the therapeutic dietitian are based on the feeding of patients on special diets as prescribed by the physician or surgeon in the treatment of the patient. It would make the life of a therapeutic dietitian much simpler if patients could be "fitted" to the dietary prescription of the doctor, rather than having to fit the diet to the patient. However, our food habits are usually deep-seated and very difficult to change. Patients often cringe at the word "diet," feeling that they will be asked to follow a restricted, distasteful, unhappy routine. Each patient must be recognized as a distinct personality, with his own habits, likes and dislikes, all of which go to make life more interesting for him, and every effort must be made to adapt his diet to suit his own peculiar eating habits. The patient who told us that he "didn't see why they said he was on a 'special diet' when all he got to eat was ordinary food" was paying the dietitian in charge of his diet a better compliment than he realized. If it is necessary for the patient to sacrifice some of his personal food habits, he must be made to understand why it is necessary. He is entitled to a better explanation than the stock "because the doctor says you have to." It is essential also that he feels that the results gained will be worth the sacrifice, or he will not stay on his diet once he is out of sight of the hospital.

In some instances, it is necessary to do some explaining to the person preparing the diet — in the case of young Johnny who was fifteen and was found to have diabetes, his mother didn't see how she could be expected to fix all that "special diet food for him when she had four other kids to feed and a house to look after, as well as a lazy, good-for-nothing husband who wouldn't work." After going over the food that she usually prepared for her family with her, and showing her that Johnny's "special diet food" was not really anything different or fancy, but just variations of that food, she decided it wasn't so bad after all. Johnny and his mother both went home much happier about the whole business, and left us more content that Johnny would get the diet so necessary to his well-being. Then there was the woman who brought "Cousin Mabel" in to see us about a week after she herself had gone home on a post-operative ulcer diet.

Miss Torrie is director of dietetics at the University of Alberta Hospital, Edmonton.

"No — Cousin Mabel didn't have an ulcer, but she thought it was so interesting being told all those things about her diet, that she wanted us to tell Cousin Mabel too; besides, you never knew, maybe Cousin Mabel would have an ulcer too some day, and she'd know all about what to do for it without having to come to the hospital — they are so expensive."

The instruction of the student nurse in the relationship between a patient and his diet is important; but also essential is the teaching of food standards and requirements in their relation to herself. The widespread education of the public in the field of nutrition and the generally wakened interest in the importance of a well-balanced diet, in these days of national food shortages, emphasize this. The student's training should provide her with a good practical background in the planning, preparation, and serving of satisfying, attractive food for "corrective" or "special" diets. She should also acquire an understanding of the relation of corrective menus to normal diets. The fact that, basically, therapeutic diets are not some "out of this world" concoctions dreamed up by someone with a grudge against humanity; but are modifications, for example, of consistency, caloric content, or the balance of basic nutrients of the normal adequate diet. She should have a healthy, reasonable attitude towards food and understand the value of following a sensible, well-balanced diet herself. She should leave the hospital prepared to teach the principles of "Canada's Food Rules" in the community to which she goes. If we do a good job of teaching this generation of nurses, we should have no bad food habits or food prejudice problems when their daughters, in turn, come to attend the school of nursing.

The term "preventive medicine" highlights the necessity of teaching medical students and internes the importance of adequate nutrition as a preventive and protective factor in health.

In addition to the formal and informal teaching of nurses and medical students, if the hospital has a post-graduate course for dietitians, their year must be planned and their work supervised, so that they get the best training possible in hospital dietetics. Because of the all-over shortage of hospital dietitians, this is an important responsibility of such a hospital.

Having dealt with the duties of the therapeutic dietitian, let us look at the duties of the administrative dietitian. Because of the fact that such a large percentage of the hospital budget is spent in her department, dietitians have advanced to positions as heads of major departments, directly responsible to the superintendent of the hospital. Not only does she carry large financial responsibilities, but problems of health and social well-being are in her hands. It is important that a hospital have a food service that is highly regarded both within the hospital and the community. Patients often express the opinion that they expect that routine hospital food will be the standard to follow for "ideal" eating habits — and they are right, it should. Their meals are pleasant breaks in the day and should be looked forward to. They should have confidence in the fact that the preparation of their food is an important item in the hospital set-up. Employees, too, should feel that the meals provided are good. Nowhere else do we find as many decided opinions about anything as we do about food. I do not think it possible to find three, even two people who will agree completely about food; but it is possible to have a food standard that will be recognized as being good.

Because of the higher food costs per dollar, it is important that hospitals have their food department well managed. Instead of the kitchen being an "orphan" department, with one person ordering supplies, another hiring staff, and still another in charge of the actual food preparation, it should be somebody's "baby"; somebody who is trained to do the job, and whose primary interest is not nursing, or housekeeping or anything

else but the production of nutritious, well-balanced meals at a reasonable cost. The job of food production management is not an easy one, but it will always be a challenge to the dietitian who enjoys working with quality food, who finds satisfaction in developing employees, and who is interested in the operation of an efficient kitchen. In order to achieve these aims, there must be a background of good organization. The work involved should be distributed systematically; there should be standards set for procedures; and there should be adequate supervision. The necessity and value of standardized recipes has been established and accepted. Cooks with years of experience will not rely upon standardized recipes because they have developed the ability to guess accurately. But the production of a uniform quality product does depend on recipes tested and standardized for amounts and methods rather than on the slipshod "pinches" of this and "handfuls" of that and "cook until done" method. The use of standardized recipes makes it comparatively easy to find the cost per serving of any food, and it is this cost per serving, not the purchase price per pound or per case, that gives you the true picture of food costs.

The hiring, training, and maintaining of a working force takes a large percentage of any administrator's time, and nowhere is it more important that it be done efficiently than in dealing with people concerned with food preparation. The handling of food is too often considered a very simple matter and no provision made for efficient supervision to see that standards of cleanliness and sanitation are taught and maintained. Cooks are supposed traditionally to be "temperamental" and when one sees the awkwardness of kitchens sometimes, one cannot blame them for living up to that tradition. The inefficiency in some hospital kitchens reflects the lack of basic information on the part of the people who planned them. We all know how each department puts pressure on the administrator for space, yet no unit in the hospital depends more on correct placement of equipment for economical production than does the kitchen. No housewife would stand for anyone telling where her stove or refrigerator should go: she knows because she has to work there. Yet institutional kitchens have been known to be set up completely, without any advice from the people who must produce results from them.

The purchasing of food supplies should be made to specification, on the basis of the use that is to be made of each particular item. For example, the purchase of No. 10 tins of vegetables for small units would result in unnecessary waste, and the purchase of vegetables in No. 2 tins would cause a lot of extra work in opening cans in a large unit. Not only should the size of container be considered, but the grade or quality to be purchased should depend on where the item is to be used. One should also note the number of servings that a tin, or a pound, or a case will yield. There are times when one item may be a little more expensive per unit, but will give more servings, making your cost per serving less and saving you money in the long run.

Proper storage for food, once it is purchased, may be a large item in food costs, and will allow you to take advantage of any offers that enable you to save money. Proper storage can also help to cut down wastage, and allow you to make the best use of left-over food.

The planning of menus is an interesting part of the administrative dietitian's routine. She must take into consideration, not only what food is available, but what equipment and staff she has to work with. There would be no use planning a meal calling for all baked food if there wasn't enough oven space to handle it, nor would there be any use planning an elaborate meal if there wasn't enough staff to prepare it. She must also plan her menus so that they are up to the standard that the hospital expects.

The keeping of proper records for personnel, equipment, and food-stuffs;

the repair and replacement of equipment; the maintenance of health standards of employees are all responsibilities of the administrative dietitian.

A very interesting period is ahead of us in the operation of food service departments of hospitals. The need for help for hospitals without a trained foods person on the staff is recognized by the fact that there are more requests from smaller hospitals than there are dietitians to fill the vacancies. It would seem a practical solution for small hospitals within a certain radius to jointly employ a dietitian who could act as an adviser on special diets and could instruct patients according to the doctor's order and in line with the approved methods of diet therapy. She could instruct the kitchen staff in the methods of preparing food for special diets. She could act as an adviser on kitchen management for efficient, economical organization, by helping with the menu-planning, the ordering of food-stuffs, the keeping of records, and the setting up of standards of cleanliness, as well as providing tested, standardized recipes and doing a certain amount of supervising. She could be included in the educational program of the hospital for the teaching of nurses and the assistance at clinics. Whatever else might be said about the life of a dietitian in hospital work, it is never dull and it is never monotonous.

The Exhibit

MARION SHORE

HEALTH exhibits of various types have been used for a good many years. From experience gathered over the years and through suggestions from advertising firms, considerable information is now available. Some splendid floats and window displays have cheered our earnest attempts, but too often our hard-pressed nurses have dreaded the advent of the annual drive for funds mostly because we feel

Miss Shore is on the staff of the Halifax branch of the Victorian Order of Nurses.

Maurice Crosby, Halifax Herald & Mail

Utilizing a store window

that as window-dressers we make better nurses. However, since public health nurses are primarily health educators, we should welcome every opportunity of preparing exhibits for any and all auspicious occasions. It is with the interest of such reluctant window-dressers in mind that this article was prepared.

Preparation of the Exhibit

Get the right people interested in your problem and keep them interested. Such persons include those associated with any firm or agency with whom you are connected or with whom you shall be dealing. If you are on the staff of a private agency, try first to get the support of your board. One interested board member will make a splendid ally. If you are contemplating a window display, approach the firm who has the best one for your purpose. Seek the opinion of the window-decorator for advice, and make use of any help you can get from him. If your exhibit is a part of a community chest drive, work in co-operation with their campaign ideas, consult their publicity-manager. Finally if your agency is attached to a national organization, seek such help as may be obtained from that source.

Your exhibit must appeal to your audience before it will attract their attention. Such pointers as are listed below may help you apply your knowledge of salesmanship psychology:

Simplicity
Unity
Novelty
Harmony
Large size
Three dimensions
Good lighting
Striking color
Movement
An idea that can be quickly grasped
Use of human figure as well as objects
Seasonal or timely
Tasteful background

The clever use of novelty, size, lighting, and motion will stop the passer-by: color and harmony should hold him, while simplicity will help him to grasp the idea readily.

If your topic is not self-explanatory you will undoubtedly require posters to interpret your meaning and to link together any fragmentary ideas. The art of poster-making cannot be discussed in this short article, but let us at least consider it as an art which lies beyond the casual ability of most of us. If possible, obtain useful posters from commercial sources, but if it is necessary to provide them locally, by all means seek professional guidance.

The accompanying illustration shows a window exhibit which received much favorable comment when it appeared in Halifax in October, 1947. The idea was to show that the V.O.N. was requesting financial support through the Community Chest in order to continue a nursing service, and that it was willing to provide that service regardless of difficulties. The window chosen was the front window of a large departmental store on a busy street. The plain background carried only the Community Chest plea and posters. The life-sized mannequin, dressed for rough weather in V.O.N. uniform complete with bag, was accompanied by an attractive poster with appropriate wording. The lighting effect in daylight was clear, at night it was subdued, giving a silhouette appearance which loomed more brightly at intermittent periods by the use of a flashing light. Color and seasonal attractiveness were provided by the addition of a branch of autumn leaves.

What really stopped the passer-by was the unique method of providing motion. A large electric fan, concealed behind the front poster, produced the effect of a very windy day with which the willing nurse is vainly attempting to cope.

The credit for this successful exhibit goes to several interested laymen and the window-dresser at the store. The V.O.N. poster was made by a friend who is an expert commercial artist. An interested board member was responsible for the entire exhibit. She also arranged for the photographer to take the picture which we trust will be helpful to any who may wish to benefit by our experience.

Chloromycetin

First reports from a United States Army test station recently set up at Kuala Lumpur, Malaya, on the most extensive experiment yet made with chloromycetin, give strong indications that the recently discovered anti-biotic may prove as effective against *scrub* typhus as was hoped. This experiment has been eagerly anticipated as a potential landmark in the history of medicine, for until the development of chloromycetin even typhus vaccine had proved ineffective against a disease which was reportedly making serious inroads among native Malayan plantation workers. Dr. J. E. Smadel, director of virus research at the Army Medical Centre in Washington, and a co-discoverer of chloromycetin, cautiously reports from Malaya on the first results of treatment of twenty-five native patients, compared with a small untreated "control" group.

Using controls composed of a similar number of Europeans, Malayans, East Indians, and Chinese, Dr. Smadel and his group found that chloromycetin markedly reduced duration of fever, period of hospitalization, and incidence of complications in *scrub* fever. The twenty-five patients to whom chloromycetin was orally administered averaged a fever period of seven and a half days, developed no complications, and were hospitalized an average of nineteen days. In addition, it was learned during the period of experimentation that both the duration and the amount of drug therapy could be materially reduced with results equally satisfactory to those obtained at the outset. The first patients received a total of 8 to 15 gm. of the drug over an average period of six days; this was eventually cut to about 6 gm. administered within a period of twenty-four hours. Of the untreated control group, one died, one developed serious complications, the mean duration of fever was eighteen days, and the average period of hospitalization was nearly thirty-one days.

Selection of Malaya as a test base followed reports of a high incidence in that region of *scrub* typhus, also known as *Rickettsial tsutsugamuschi* and as "Japanese River Fever." During the war with Japan, many Malayan plantations fell into disuse and were allowed to go back to brush. This resulted in an increased population of rodents, thought to be a carrier of the rickettsia-bearing mite. Native workers were sent in to clear the plantations, and a heavy mortality rate was said to have resulted.

All twenty-five patients in the treated group received an initial oral dose of approximately 50 mgm. of chloromycetin per kilo body weight, and were subsequently given 0.2 to 0.3 gm. of drug by mouth every two to four hours for a variable time. During the early part of the present work, treatment was continued until at least the twelfth day after onset; these patients received totals of 8 to 15.5 gm. of drug. The duration of treatment was gradually shortened and the last seven cases were given the drug for only twenty-four hours; these received a total of about 6 gm. during this period. Their responses with this short regime were as satisfactory as with the longer periods of therapy.

Determinations of the amounts of drug present in the bloods of these patients have not yet been made because of technical and supply difficulties. It is of interest that chloromycetin can be employed successfully without dependence upon the results of such assay techniques. The practicality of the use of chloromycetin is further emphasized by the fact that twelve of the twenty-five patients were treated in estate hospitals where conditions are no more favorable for complete nursing care than in the average private home in the United States.

Chloromycetin is highly efficacious in the treatment of patients with *scrub* typhus. It is simple to administer and has not been found toxic for man.

Previous laboratory experiments with chloromycetin have showed considerable effectiveness against rickettsial diseases other than *scrub* typhus. The drug has even been found to be mildly effective against one virus disease, psittacosis (parrot fever), although it must be borne in mind that the psittacosis organism is one of the largest of the viruses and just falls short of being classified as a rickettsia.

— *U.S. Army Technical Information Office*

The art of medicine consists in three things: the disease, the patient, and the physician. The patient must combat the disease along with the physician.—HIPPOCRATES "*Aphorisms*"

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

The Victorian Order of Nurses in Industry

CONSTANCE LELEU

A SHORT time ago, while endeavoring to explain our health service to a young male employee, he suddenly exclaimed, "I get it. You're a sort of Dorothy Dix." At first I was tempted to laugh, as probably you are, but, when I stopped to think about it, the old proverb came to me, "If the cap fits, wear it." Not that our purpose is to give advice to the lovelorn, although at times we do give it a more professional term, but how often family problems are the cause of absenteeism! How frequently major accidents are caused when a worker is worried with home difficulties! Even in smaller mishaps, an employee will often admit his thoughts were with a sick wife or child. Improper diet, the cause of much illness and malnutrition, may often be related to unhappy meal-times and lack of interest on the part of the meal planner or lunch-box packer. So you see, we do need some of the illustrious lady's wit and wisdom.

Our present service was incorporated four years ago at the height of the production period. Nearly all the large plants in our industrial city had full-time nurses on their staffs, but the majority of workers were employed in industries employing less than one hundred workers. What of their health and accident care? One firm was faced with an epidemic of pediculosis and sent for the Health Department. Their nurses did a good job and so impressed the management that they requested the department to continue the service. As this type of work was not considered a municipal responsibility, the request was forwarded to the Industrial Division of the Academy of Medicine. When this body convened and studied the matter, it found there was a definite need for, at least, a part-time industrial nursing service in the smaller plants, and referred the question to the Industrial Nurses' Organization. From this group of nurses came the suggestion that, as the Victorian Order was giving part-time service to the homes, they might be prevailed upon to extend their services to industry.

However, this was a comparatively new undertaking for the Victorian Order and considerable groundwork and self-examination was needed within its own organization before a definite answer could be given. With the current nurse shortage, could the Order spare nurses for this new project? Due to the trend of hospitalization for confinement and the successful use of chemotherapy in pneumonia and other diseases, many former nursing hours were being released to be put to other uses; why not use them to meet this demand? Was the Victorian Order nurse capable of giving this

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type of service? The industrial nurse needs more qualities than proficiency in bedside nursing. The staff nurse has been trained from the beginning to incorporate health teaching into her daily care of the sick or newborn. With her family contacts in the home she sees, as it were, behind the scenes of the industrial worker's life and can understand its effects upon him and his work. Her association with people in all walks of life enables her to meet people and adjust her perspective to theirs, showing herself friendly, interested in all their joys or sorrows. What better experience along with her hospital and university training could fit her for this new venture?

Even with this experience, however, it was felt that additional knowledge was needed to meet the problems peculiar to industry. A nurse with experience in this type of service was transferred to Hamilton to inaugurate the service. Gradually, by observation, reading, refresher courses, conferences and supervisory guidance, others were prepared.

Periodic conferences of those taking part in this special activity, discussing common problems, and new methods, keep us alert to the needs of our plants — as does the visit of the supervisor to our health service room.

With the permission and assistance of our National Office, Ottawa, the acting supervisor prepared a letter outlining the wisdom of adopting this service, which was presented and approved by the Victorian Order of Nurses' local Board of Management. Letters were sent to all industries known to have no nursing service. A notice was inserted in an industrial publication. The Academy of Medicine, and particularly all doctors either giving part-time or on emergency call for plants, gave the plan their whole-hearted support. The Provincial Division of Industrial Hygiene also allowed their nurse consultant, Miss S. Wallace, to visit us and give valued assistance in the initial period and in meeting later problems.

Three requests were received and the managements, after receiving details from the Victorian Order of Nurses supervisor and the chairman of the Industrial Division of the Academy of Medicine, were eager to try the plan as soon as possible. In determining the number of hours to be spent in the plant, the number of employees was considered, together with the incidence of occupational accidents or illness, or any other particular problem. Today we have eight industries; one receives three hours weekly, four others — five hours weekly. Two more each require daily two-hour visits, and in our largest industry, with an employee population averaging four hundred, the nurse spends four to five hours a day.

The cost of this service to industry is based on the local cost per visit. At present, a rate of $1.50 per hour is charged for the first two hours, with the reduced rate of $1.25 per hour for additional time that is required. One large plant, having a full-time nurse, requested home visiting for their sick employees for which they pay the usual cost per visit. Other industries, having group sick benefit plans with companies giving home nursing services, are contacted through their own medical department to whom the nurse makes her report.

During the initial conference between the management and the supervisor the understanding was reached that the nurse was to give a health service (to be known as such) with supervision of first aid, under the direction of a part-time or "on call" company physician. A list of equipment and necessary floor space were also decided upon. Before arrangements were completed the nurse was introduced to the management, to the foremen and, in the smaller industries, to the employee group to whom the service was interpreted. She then made a tour of the plant and saw the employees at work. A visit was made to the designated doctor who prescribed the drugs she would be using and advised her of his wishes regarding procedures and treatments. Later

these orders, signed by the doctor, were posted in the health service room. To gain the confidence of existing first aid workers and to train new ones to follow these orders in the nurse's absence takes patience and tact, but this can be accomplished without hard feeling.

One visitor asked, "How did you get employees to come?" Did she not know the curiosity of human nature? From infancy to old age we all like to inquire into anything new. Any excuse, from a headache to a small scratch, was a reason to see the nurse; from then on, it was up to her. No sick or injured employee departed without some advice for a discovered need in the diet, habits, or general health. All new employees are interviewed, the service explained, any health problem or defect noted. Foremen are encouraged to report employees absent through illness longer than two days. These workers are visited either by the plant nurse or the Victorian Order nurse in the district and a report given. No charge is made for these visits unless nursing care is given, then the usual Victorian Order of Nurses procedure is followed. Employees returning to work following illness are checked to see if they are ready to return to work, to discuss possible physical examination of their fitness to return to the same work. If an illness or accident is considered to have been preventable, the employee is shown how to prevent a recurrence. Gradually confidence has grown, barriers have been broken down and the nurse making her monthly report sees behind those bare figures, problems not only of employees' health but those of husbands, wives, and children, too, that have been brought to her, not only for help, but just to be able to tell someone who tries hard to understand.

The officials of the companies are all keen business men and are used to seeing profits from their investments. How to prove to them that a health service pays is where records come in. In plants where there is no regular medical participation, a simple employee record card is in use. The general information on the heading is completed by the business office at the time of employment. Where physical examinations are included in the health service, a card similar to that used in schools is added. A daily and monthly classification summary sheet is an important part of the record keeping. This form has been gradually worked out to meet our need. All visits to the health centre are recorded and special note made of outstanding problems for future teaching; specific data for accidents are recorded in case this information is required by the Workmen's Compensation Board, with whom the nurse works closely. These records are kept in a locked file and are open only to the nurse and doctor. Any information drawn from this source and used in giving monthly reports to the management is purely impersonal but not always necessarily statistical. Record forms are supplied to the firms at cost.

As we look back over these monthly reports and see the ever-increasing totals, it is too soon to draw conclusions. At least the four years have taught us, the Victorian Order nurses doing industrial nursing, that this type of nursing is what you make it. To bandage a cut finger is one thing, but to get to the needs of the owner of that finger, whether they be physical, mental, or social — that is the challenge; may we never forget or forego our responsibility.

Teamwork

The goals of public health programs are so varied that they can never be attained by a single method of attack. Only through the teamwork of all community health agencies can there be hope for worthwhile achievement. — *Connecticut Health Bulletin*

A Public Health Nurse at a Grenfell Nursing Station

I visited in one of the little coves, some fifteen miles distant from my nursing station, more or less a routine visit, to immunize some of the school children, to check up on a few strays and to give pre-natal instruction to two of my expectant mothers. I was asked to call at a house where a young woman "was took wonderful bad." When I reached there I found to my horror that this woman, who had been in labor for twenty-four hours, was having convulsions at regular intervals. The family was taking it calmly, and had just burned her stocking, "to cure the fits." As soon as a motor-boat could be launched in the heavy sea, we started out for the nursing station, with six men, the patient, and myself. The wires were down and no doctor or even advice could be expected from the hospital — many miles distant. Some twenty hours later the patient was delivered of a macerated monstrosity and only after eighteen hours was the placenta manually expressed. Running a temperature of 104° to 105.4° and with a rigid abdomen, an infected tongue which had been badly bitten (in the early convulsions), quite delirious and incontinent, the young woman was still having the occasional convulsion. From symptoms, which were developing, I feared a lung abscess before the stormy seas might subside to allow us to get to hospital.

In the meantime I had to admit a primipara who was at term. On the fourteenth day for my post-partum patient we set out at daybreak in an open motor-boat with a canvas cover thrown up as a sort of tent. I had both patients to carry along as I dared not leave the expectant mother behind. We travelled all day, and I gave stimulants to one patient and sedatives to the other. On arrival at hospital proper treatment and medication were commenced immediately on my post-partum, while an uneventful delivery took place eighteen hours later on the young mother. In a month, I met the coastal steamer to bring ashore both patients alive and well — and also a lusty infant, a future fisherman.

— JEAN SMITH

Rehabilitation Study

In Canada today, there are a great number of potential wage-earners, exactly how many is not known, who are unable to earn their living because of some physical or mental handicap. The Department of Veterans Affairs and the Workmen's Compensation Board have demonstrated what can be done to rehabilitate veterans with war disabilities and workers who have been injured in the course of their employment, but there is a large group of handicapped citizens who are not eligible for the services provided by either of these organizations and for whom there is no similar program of rehabilitation. Recent developments in the United States and Great Britain have shown that given adequate rehabilitation services, most handicapped citizens can earn their own living and live happy, useful lives in the community.

Several member agencies of the Community Chest of Greater Toronto have been concerned for some time about the needs of the civilian handicapped in Toronto. They have, therefore, established a committee in the Division on Health with Miss M. Clarke, director of Welfare Services of the Canadian National Institute for the Blind, as chairman, to study the problem. The first step is to find out, approximately, how many handicapped persons there are and what services are available for them. When these facts have been collected, they will be used as a basis for discussion of what further provision should and could be made in our community to improve and extend existing services for the civilian handicapped. The committee has started its work. The study is under the direction of Professor John S. Morgan of the School of Social Work, University of Toronto. Further information on the work of this committee can be obtained from Mrs. Libbie C. Park, secretary of the Division on Health, Welfare Council Department, 100 Adelaide St. West, Toronto 1, Ont.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Nursing Care in Hospital Services

MARION MYERS

WE ARE frequently reminded these days of a situation created by science in which the rapid progress of physical and chemical power has brought the peoples of the world into very close physical and economic relationship before there was sufficient understanding among these same people to enable them to live as closely together as these advances demand. Consequently, it would seem that a most fundamental factor, social science, is sadly lacking in this era of rapid scientific progress. The progress and advance in hospital services is a bit analogous to this. Hospitals are continuing to increase their services at a rate often in advance of the internal factors necessary for such an advancing program.

Behind all this there are, of course, many reasons, not the least of which is better curative and preventive medicine. Hospitals are constantly being geared to participate in this improved medical treatment which, in turn, has more often only been possible because of good hospital standards. Into this progressive picture hospitals are endeavoring to keep pace with the following:

1. Modern standards of living (especially high in this country).
2. The demands of medical practice as a result of scientific developments.
3. The adoption of methods used by Big Business.
4. More and more involvement with the policies of other groups — social, financial, governmental, etc.

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HOSPITAL'S RESPONSIBILITY

With the admission of every patient the hospital enters into an implied agreement or contract to furnish adequate care to the patient. I shall discuss one important aspect of this hospital responsibility, "The Nursing Care," under the following headings: definition — responsibilities — supply and demand.

WHAT IS NURSING CARE

I know of no better definition than that postulated by Miss Bertha Harmer: "Nursing may be defined as that service to the individual that helps him to maintain or attain a healthy state of mind and body, or, when a return to health is not possible, relief of pain and suffering."

The aims of both hospitals and physicians emphasize this definition. The patient restored to health and able to take his place in society is the common goal.

Of all the services provided in any hospital, nursing is the one which comes closest to the daily life of the patient. Nursing may be likened to a welding force bringing to fulfilment in the patient the worthwhile benefits of such special therapy as surgery,

nutrition, drugs, etc. The difficulty seems to be that in the eagerness to obtain the best health results, standards and methods have been set up which, under our present system, tend to promote good nursing care on the one hand and retard it on the other. For instance, on the helpful side we have:

1. Improved nursing equipment (although not well standardized yet).
2. Standardization of hospitals with all that that implies.
3. Better living conditions.
4. Provision for medical and hospital care.

On the other hand, due to the very strategic situation that nursing occupies in hospitals, which is somewhere between the application of medical and social science and the laboratory of research, it is exposed to all of their changing and progressive methods, essentially good in themselves but which, at the same time, tend to superimpose a load on nursing which, under our present system, cannot always be satisfactorily carried. This leads to frustration and dissatisfaction, especially among the nurses themselves, and of course inhibits good nursing care and goes a long way toward attracting them to other fields.

Main Responsibilities of Nursing Care

For good results, nursing must associate itself with the progress of medical science. Today, more and more treatments which were previously performed by doctors are being passed along to nurses.

Diagnosis continues to demand more and more laboratory procedure, and although this diagnostic work does not in a sense take place on the wards, nurses more often have to be responsible for the proper integration of the laboratory and the patient.

Nursing has always been concerned with the observation of the patient. This responsibility has not changed in principle, but has greatly increased in content.

Much prescribed treatment, both curative and preventive as well as the physical and mental needs of the patient, continues to be a specialty of nursing care. Perhaps the most important part of this responsibility is what might be called "The Nurse-Patient Relationship." In this I would include the many hours of care that are not always realized when estimating the time required for different treatments. *Examples of this are:*

Hours of extra nursing care due to the patient's age, mental state, poor vitality apart from present illness, helplessness, nationality, slow adaptability, etc. These individual differences must be dealt with through gentleness, firmness, persistence, patience, reasoning, and explaining. Good care must be alert to many concomitant needs such as:

(a) Promotion of nutrition by the little things that encourage the patient to take food.

(b) Protective devices for tender skin or emaciated bodies.

(c) Support and change of position for the more helpless and weak.

(d) The dispensing of more or less heat or cold as the individual need demands.

(e) Watchfulness, especially at night, following treatments, and for the irresponsible.

(f) Understanding and patience with the friends and relatives of patients.

(g) Health teaching, if benefits received in hospital are to continue.

These cannot be included in any time study of treatments. They vary from patient to patient, from hour to hour. It is the nurse-patient relationship which is the very soul of good nursing care. It is this association to which the student nurse must be exposed if she is to gain a true appreciation of the art of nursing.

Much discontent and lack of stability among nurses today may be traced to situations where this finer form of nursing cannot be given, due often to lack of sufficient help, both subsidiary and qualified, poor organization, and other demands. Time is necessary to any well-finished work. Nursing is no exception.

Some Causes of Shortage

The increase in social security plans, as well as a more developed health consciousness on the part of the public, encourages a greater number of people to go to hospitals.

The opening of new fields has attracted a certain number of nurses from hospital work. The system of nurse supply has changed little since the first hospital schools of nursing were established in this country. This is now out of line with present day supply and demand. As a result, schools are maintained by hospitals providing all types of service. Students are carrying too great a responsibility for the nursing care before they are properly prepared to do so.

Supply and Demand

In Canada today we have 170 schools of nursing. These vary greatly in size and number of students. According to a study made by the Canadian Nurses' Association, the number graduating in 1947 was 3,774. Since 1940 the yearly output of graduate nurses has maintained an average of slightly over 3,500, but together with this yearly augmentation we must remember that many of these nurses do not take up hospital work.

In 1943 a very extensive study of nursing supply was made and, although these figures are not accurate today, they serve as a guide. The 1943 study revealed that there were 10,717 graduate nurses in hospitals and 11,419 graduate nurses in other services. Of the latter group, 6,327 were in private duty, leaving a total of 5,092 in fields outside hospitals, mainly public health nursing. Only fifty of this number were unclassified. In December, 1946, the Canadian Nurses' Association reported a total of 33,338 graduate nurses. This is an increase over the 1943 figures due mainly to:

1. Return of nursing sisters, a great many of whom are employed in veterans' hospitals.
2. More of our young married nurses continuing in their professional work, especially in the private duty field.
3. An active program for recruiting student nurses, carried on by the provincial nurses' associations since 1942.

A review of our supply resources reveals the following: Hospital schools are by far the largest source of supply for all fields of nursing. Most of the funds available for the preparation leading to graduation come from hospital budgets. Hospital schools cannot supply sufficient nurses to meet the present-day demands and provide nursing care in keeping with their own expansion.

The Student Nurse

In addition to discussing the graduate nurse situation of today, I should like to refer briefly to the position of the student in this nursing care picture.

This is the old story of divided loyalties between the hospital and the nursing school with which you are all familiar. Nevertheless, hospitals and nurses' associations are still trying to provide nursing care and education under a system which today does not adequately meet either the needs of the hospital nor those of the student. This is no plea for separation from the hospital; neither is it a criticism of what hospitals are doing. Both are victims of a plan out of line with the present-day requirements of each.

This year the Canadian Nurses' Association, through the help of the Canadian Red Cross Society, has started an experiment in a basic two-year undergraduate course for student nurses. This school will be a hospital school. The students will work in the hospital but their program will not have to be regulated according to the varying needs of the hospital. It is hoped that by thus having a program where the nursing course may be conducted more in keeping with the needs of the developing student, she may be prepared more quickly and at the same time enabled to retain her ideals and satisfaction in nursing. If such a system is proven to be sound, it would seem that public support must be provided to meet part of the cost, and the hospitals relieved of some of the burden of nursing education.

Finally, if we would safeguard and improve the quality of nursing care, the closest co-operation between hospital administrators and nursing is essential. Let us hope that governments, too, will feel a responsibility to this type of education, so vitally

related to the public need.

The student nurse must be exposed to what is finest and best in nursing if we are to produce what it takes to nurse people better, and promote the "Better Health" we are all aiming toward.

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In the Good Old Days

(*The Canadian Nurse*, July, 1908)

"It is the duty of the school nurse to attend to the general cleanliness and health of the pupils, to report cases of deafness, imperfect eyesight, skin eruptions, and apply such treatment from day to day as may be directed by the medical officers. If need be, she follows the children to their homes to see how they live, or to give such instructions as may improve the conditions of living, reporting also to the proper bureau, destitution in families, bad sewers, or children with contagious disease working on clothes in sweat-shops. These nurses may be regarded, therefore, as sanitary-missionaries."

"In hospitals, physicians and nurses are so on the *qui vive* to make records in restoring health to those overtaken by acute diseases, they have little time to devote to the one who is to be always "shut-in"— the incurable. He or she is promptly dubbed rather a nuisance, and the poor patient soon arrives at the same conclusion. Clearly, there is but one reasonable solution of the problem: there must be suitable places provided for these sufferers."

"The petition of the nurses in the Toronto General Hospital for an eight-hour day is a sign of the times . . . The superintendent, with all the difficulties of the situation before her, has succeeded in giving the 127 nurses now on duty there a half-day, beginning at 12:00 noon, each week, for the summer at least."

"Miss Bateman, one of the nurses at St. Michael's Hospital, saved the life of a delirious patient, who was about to throw himself from the balcony. Miss Bateman, with great courage and resolution, kept the patient from endangering his life until help arrived."

"Miss F. Madeleine Shaw, instructress of nurses, Montreal General Hospital, and Miss Young, assistant superintendent of nurses, sailed from Montreal early in June by the *S.S. Ottawa* for England."

Worry

Severe, prolonged worry, whether warranted or not, is invariably complicated by one of these fears — fear of illness, failure, death, poverty, or loss of love. The worry is incurable until the fear is faced. Emerson wrote, a century ago, "Do the thing you fear and death of fear is certain" and his advice is still sound today. First conquer your fear by hauling it out of its dark corner and holding it up to the light. Once you've done that, you'll begin to wonder exactly what it was that you were so worried about.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Le Facteur Rh

IVAN W. BROWN, JR., M.D.

DEPUIS 1940, une révolution s'est opérée dans les connaissances médicales du facteur Rh. Des articles l'ont rendu responsable de bien des maux, depuis l'avortement jusqu'à la débilité mentale.

A cause de cette littérature, le public y a ajouté trop d'importance. Tâchons de faire la mise au point et de voir clair.

Le facteur Rh est un agglutinogène du sang comme les facteurs A.B.O. qui déterminent le groupe sanguin. Il se trouve dans les globules rouges du sang, chez 85 pour cent des peuples de races blanches, chez 90 pour cent de peuples de races noires, et chez 99 pour cent de Chinois. La présence ou l'absence de cette agglutinogène est uniquement due à l'hérédité et est transmis par l'un des parents ou par tous les deux. Si les globules rouges contiennent le facteur Rh, l'individu est dit "Rh positif"; s'il est absent, il est dit "Rh négatif."

La limitation de cet article ne permet pas un exposé sur le problème complexe de la génétique sur lequel est basée l'hérédité du facteur. (Pour plus de clarté l'exposé a été simplifié, et pour des raisons techniques, les diagrammes ont malheureusement dû être supprimés dans la traduction.) Si un individu Rh négatif reçoit du sang Rh positif, il peut présenter une sensibilisation. Cette sensibilisation est causée de deux différentes manières:

1. Par une transfusion de sang Rh+ à un receveur Rh—.

2. Chez une femme Rh— enceinte d'un foetus Rh+. L'agglutinogène passe dans la circulation de la mère et produit une sensibilisation. Ce dernier mécanisme est le plus fréquent. Toutefois il est à noter que cette sensibilisation ne se produit pas chaque fois que du sang Rh+ est transfusé à une personne Rh— ou chaque fois qu'une femme Rh— est enceinte d'un foetus Rh+.

En réalité, pas plus de 5 pour cent de femmes Rh— développent une sensibilisation causée par une grossesse Rh+. Ceci ressort du fait qu'à peu près 12 pour cent de mariage sont contractés entre un homme Rh+ et une femme Rh—. Un nouveau-né atteint d'érythroblastose (maladie résultant d'une incompatibilité du facteur Rh) ne survient qu'une fois pour 150 naissances.

La fréquence de la sensibilisation au facteur Rh, produite par transfusion du sang Rh+ à un sujet Rh—, n'est pas encore exactement connue, mais il ressort des dernières constatations, faites durant la guerre, que 50 pour cent des soldats pouvaient développer une sensibilisation. Une fois que des globules rouges Rh+ entrent dans la circulation sanguine d'un individu Rh—, il est susceptible de former une sensibilisatrice. Des anticorps Rh, nommés agglutinines Rh, se forment dans le plasma et ce sujet offre une défense à tout nouvel apport

Extrait d'un article paru dans l'*American Journal of Nursing* (Jan. 1948). Traduit par la *Revue de l'Association des Infirmières Catholiques Belges.* (avril-mai, 1948.)

de sang Rh—. *En effet les anti-corps détruisent les globules rouges Rh+ et une forte réaction accompagne l'hémolyse.* Malheureusement, il n'y a pas de test qui détermine si l'individu aura une sensibilisation. Il s'ensuit que tout individu Rh— doit être regardé capable d'offrir une défense. Actuellement, la science n'a pas encore prouvé que la présence d'anti-corps Rh était préjudiciable à la santé, à la condition toutefois qu'il n'y ait pas un nouvel apport de sang Rh+. Dans ce cas, il y aurait une hémolyse des globules rouges Rh+ et la partie colorante d'hémoglobine est mise en liberté. Très nocive pour les reins, elle provoque de l'anurie de l'urémie et entraîne souvent la mort. Il n'y a, cependant, pas de danger de transfuser du sang Rh— à un receveur Rh— qui a développé une sensibilisation. Les anti-corps que ce dernier a fabriqués ne trouvent pas matière à destruction. Pratiquement, à part les très rares cas de sensibilisation au facteur Rh, un sang compatible avec celui du malade et Rh— peut-être donné, sans danger de provoquer une sensibilisation ou une réaction. Le sang du groupe O et Rh— est maintenant reconnu, en cas d'urgence, donneur universel.

Le résultat le mieux connu du facteur Rh est son action sur une 2de ou une gestation ultérieure chez une femme qui antérieurement a présenté une sensibilité causée par une transfusion ou une grossesse.

Les anti-corps de la mère passent dans la circulation foetale et détruisent les globules rouges Rh+ de celui-ci. Il ressort donc que la sensibilisation a plus d'importance chez une femme que chez un homme. Il est utile d'éviter une sensibilisation chez une femme.

La destruction des globules rouges Rh+ du foetus, résultant d'une incompatibilité du facteur Rh, est connue sous le nom de "érythroblastose foetale." A la naissance le nouveau-né présente de profondes modifications du foie, de l'encéphale, et d'autres organes. Ces altérations peuvent entraîner la mort in-utéro. Si, né vivant, il peut offrir des anomalies de l'encéphale, un ictère et une anémie graves du nouveau-né. Parfois, il est apparemment sain et l'ictère n'apparaît qu'entre la 6e et la 72e heure, après la naissance, à la suite d'une crise hémolytique entraînant la mort.

Cette dernière année beaucoup a été fait pour établir un diagnostic et un traitement adéquat. Par des transfusions multiples, aussi rapidement que possible après la naissance, bien des enfants ont été sauvés. En même temps qu'on fait une transfusion de sang Rh— de préférence par le cordon ombilical, on fait une saignée pour éliminer le sang Rh+.

Une intéressante découverte est la présence dans le lait maternel d'un anti-corps Rh chez la mère Rh— sensibilisée. L'allaitement maternel offre donc un sérieux avantage de plus pour un bébé atteint d'érythroblastose.

Durant ces dernières années, l'étude de l'hérédité du facteur Rh a acquis une certaine importance en médecine. Landsteiner et Wiener ont démontré que le facteur Rh est transmis comme une simple dominante suivant la loi de Mendel, Rh+ étant le caractère dominant. On hérite la moitié des caractères du père et la moitié des caractères de la mère; mais les caractères transmis dépendent des combinaisons des cellules reproductrices et de leur dominante. Il découle de ce qui précède que les sujets Rh+ peuvent être divisés en deux groupes:

1. Les individus Rh+ homogènes qui héritent le caractère Rh+ et du père et de la mère et dont les cellules reproductrices transmettent uniquement le caractère Rh+.

2. Les individus Rh+ non homogènes qui ont le caractère Rh+ d'un des parents et le caractère Rh— de l'autre.

Depuis que par des tests sérologiques, on peut déterminer si les globules rouges sont homogènes ou non dans certains cas, il est utile de connaître leur constitution fondamentale. La recherche de la transmission du facteur Rh intéresse aussi la médecine légale en déterminant le groupe sanguin d'un individu. Wiener a démontré qu'antérieurement à ces connaissances, un homme faussement accusé de paternité n'avait que 35 pour cent de chance de prouver son

innocence par des tests hématologiques tandis que maintenant il en a 45 pour cent.

Ces connaissances nouvelles sur la transmission du facteur Rh ont aidées les anthropologistes dans l'étude de la migration de certains peuples, et dans l'origine de certaines races.

A la lumière des connaissances actuelles sur le facteur Rh, voici quelques conseils pratiques:

1. Après avoir pris avis de son médecin, toute femme enceinte aura son facteur Rh déterminé par un laboratoire compétent.

(a) Si elle est Rh+, probablement elle n'aura pas de difficulté.

(b) Si elle est Rh—, elle ne doit pas s'alarmer. Seulement si son mari est Rh+, elle a 5 pour cent de risque. On recherchera dans le sang la présence d'anti-corps surtout durant les derniers mois de la grossesse.

On déterminera aussi le caractère homogène Rh du mari.

(c) Si on trouve des anti-corps: Durant les derniers mois de la grossesse, on fera de fréquents dosages des anti-corps pour savoir à quel moment exactement il faut interrompre la grossesse pour sauver l'enfant.

Etablir le génotype du mari, savoir s'il est Rh homogène ou non.

S'assurer qu'on pourra avoir au moment de l'accouchement du sang du groupe O, Rh— pour qu'éventuellement on puisse faire une transfusion au nouveau-né.

2. Il est prudent de déterminer le facteur Rh du malade à qui on fait une transfusion sanguine. Il ne pourrait recevoir que du sang Rh— et d'un groupe compatible avec le sien. Ceci est surtout important pour les transfusions chez les femmes enceintes Rh—. Elles ne pourraient recevoir que du sang Rh— et compatible avec le leur.

On se rappellera qu'un mariage entre une femme Rh— et un homme Rh+ n'est pas nécessairement catastrophique. C'est la sensibilisation qui est importante. Celle-ci peut être prévenue lors des transfusions. Si un danger existe, le sang sera examiné à chaque grossesse. Souhaitons que la science découvre un procédé de désensibilisation, pour que les mères Rh—, qui ont une sensibilisatrice, mettent au monde un enfant Rh+ normal.

Seasonal Incidence of Disease

Most communicable diseases show marked seasonal variations and may be grouped according to their season of maximum incidence.

The respiratory diseases, typified by the common cold, influenza, and pneumonia, provide an outstanding example of the effect of season on the occurrence of illness. The incidence of these diseases is at a minimum during the summer, but the number of cases begins to increase thereafter, reaching a peak in January. Influenza reacts more sensitively to seasonal changes than does pneumonia. Inasmuch as the common cold is not a reportable disease, data are not available to show its seasonal pattern, but experience tells us that it follows a course similar to that of the other respiratory infections.

For some reason, the spring favors the growth and spread of some of the coccus group of bacteria. Typical of the infections of this group are septic sore throat, scarlet fever, and epidemic meningitis, all of which reach their highest incidence in March. Measles, which appears to be caused by a virus, likewise shows a rapid rise in cases during the winter months and a maximum in the spring. After reaching its highest point in April, the incidence of measles declines very rapidly to a minimum level in August.

The infections characteristic of winter and spring hardly have passed their peak when the most common diseases of summer begin to make their appearance. These include such diseases as typhoid fever and bacillary dysentery, both of which are usually caused by polluted water, milk, or other foods. Also included in the summer group are acute poliomyelitis and infectious encephalitis, and the mosquito-borne diseases — malaria and yellow fever. Although the first two of the diseases just mentioned both attack the central nervous system, encephalitis shows a greater concentration of cases in summer than does poliomyelitis. Nearly one-fourth of all encephalitis cases are reported in the month of August, after which the incidence of the disease declines rapidly. Cases of poliomyelitis, however, continue to increase in number until late September, and then begin to decrease. Diphtheria reaches its high point a little later in the year — in October and November.

— *Statistical Bulletin*
of the Metropolitan Life Insurance Co.

Nursing Profiles

At Stratford, Ont., on April 17, 1948, a beautiful and significant tribute was made to the rich personality, great career, and lifetime service of **Alexandra Munn** by the Stratford General Hospital Alumnae Association, when they presented the hospital with Miss Munn's portrait painted by Archibald Barnes, R.A.

Miss Minerva Snider, the present superintendent of the General Hospital, at the presentation ceremony, paid honor to Miss Munn as student, graduate, superintendent of the hospital and then, until 1947, director of the Nurse Registration Branch under the Ontario Department of Health. "This day," added Miss Snider, "is paying tribute to that indefinable something that is the essence of our existence — an ideal."

Dr. David Smith, who gave the principal address, not only paid homage to Miss Munn but to the service of which she was an emblem. "We are not recognizing Miss Munn alone, but what she has done."

Speaking on behalf of the nurses of Ontario, Miss Edith Dick referred to the widespread significance of Miss Munn's work and the high esteem in which she is held by all. "We know her to be a charming and gracious person," she said, adding that it is a privilege to enjoy association with her, the richness of her thoughts, and her happy humor.

The presentation of the painting which portrayed some inner quality of the person; the portrait of a great woman; the various spoken expressions of glowing pride in all that Miss Munn stood for, will be a vibrant memory for all those who had a part in making this lasting tribute. Every nurse who has indirectly benefitted by Miss Munn's service to her profession will be gratified and every nurse who knows Miss Munn will rejoice.

Jones & Morris, Toronto

ALEXANDRA MUNN

Fay Lillian Rutledge, A.R.R.C., has been appointed to the dual post of director of nursing with the Royal Canadian Navy and nursing officer at the Royal Canadian Naval Hospital, *H.M.C.S. Stadacona* in Halifax, with the rank of Lieutenant Commander (N.S.).

A native of Streetsville, Ont., Lt. Cmdr. Rutledge graduated from the Toronto General Hospital in 1928. She joined the Royal Canadian Navy as a nursing sister in August, 1943. Her first appointment was to *H.M.C.S. Stadacona* and from there she went to the naval hospital at St. John's, Newfoundland, in 1944. She returned to Stadacona in 1945 and in May, 1946, she became matron of *H.M.C.S. Naden* at Esquimalt, B.C. In June, 1946, she was awarded the Royal Red Cross (Second Class). Her citation reads in part: "Her cheerfulness and high moral character have been an example to her staff to whom she has displayed an understanding and sympathetic attitude."

Miss Rutledge enjoys a game of golf when her duties permit free time. She is also a member of the Rifle Club of the R.C.N.

LT. CMDR. F. L. RUTLEDGE

Lucie Woodrow has been appointed director of nursing at the Royal Jubilee Hospital, Victoria, B.C. Graduating from the Vancouver General Hospital in 1921, Miss Woodrow engaged in post-graduate study at the Nursery and Childs' Hospital, New York. She was on the staff of the County Hospital, San Diego, Calif., prior to her appointment as night supervisor at the Royal Jubilee Hospital in 1930.

Mary Craig Murphy, who was born at Dawson, Y.T., educated in Nova Scotia, and who is a graduate of the Toronto General Hospital, has been appointed matron of the Red Cross Hospital at Yellowknife, N.W.T.

Miss Murphy served in Scotland from 1941 to 1945 with the Red Cross Orthopedic Unit from Ontario. Prior to going overseas, she was on the staff of the Copper Cliff Hospital. Miss Murphy and her staff administer to the needs of five thousand whites, half-breeds and native Indians scattered north from the bleak shores of Great Slave Lake.

Alice Bush has resigned from the staff of the Trail-Tadanac Hospital, B.C., to take a position with the Department of National Health and Welfare as matron in charge of their Coqualeetza Indian Hospital at Sardis, B.C. A graduate of the Winnipeg General Hospital in 1932, Miss Bush was on the staff of Trail-Tadanac Hospital from February, 1936, until March, 1943. She joined the R.C.A.M.C. and served in England, Italy, and Canadian military hospitals. She was awarded the Royal Red Cross (Second Class) for her army service. She re-joined the staff of the Trail hospital in November, 1946.

Miss Bush has been active in association affairs, acting as secretary of the Trail Chapter, Registered Nurses' Association of British Columbia, for the past year.

Edith Sarah Mignon Kerr, a native of Saint John, N.B., who graduated from New York Hospital in 1911, has retired from her post as assistant matron at Lancaster D.V.A. Hospital in Saint John after twenty-four years of service. Miss Kerr joined the C.A.M.C. in 1917 and served in Canada and England. On the occasion of her retirement a delightfully arranged tea was held in her honor during which a gift of flat silver and Wedgewood service plates was presented to Miss Kerr.

MARY MURPHY

The nursing staff of Camp Hill Hospital, Halifax, N.S., has honored two of the staff who have recently retired after many years of service. **Josephine C. Cameron,** a native of Pictou, who graduated from the Victoria General Hospital, Halifax, and saw overseas service during the first World War, retired after twenty-eight years' service. Until recently, Miss Cameron was assistant matron at Camp Hill. **Ethel (Warner) Young** resigned from the nursing staff where she had served for fifteen years. At the time of her resignation, she was supervisor of the operating-room. Mrs. Young was also a graduate of the Victoria General Hospital.

ALICE BUSH

In Memoriam

Martha Olive Bradley, the first industrial nurse in Canada, died in Welland, Ont., on April 9, 1948.

Mabel Una Dale, a graduate of the Calgary General Hospital, died in Red Deer, Alta., on April 23, 1948, at the age of forty-seven. Miss Dale had been matron of the Didsbury Hospital for the past year.

Jane Halliday, who graduated many years ago, died on April 8, 1948, in London, Ont., in her eighty-fourth year.

Ferne E. McIntyre, who graduated from the General Hospital, Regina, in 1926, died at her home in Mountain, Ont., on August 18, 1947. After her graduation she was school nurse in Melville, Sask., for several years. In 1944 she joined the staff of the Ottawa Civic Hospital where she was in charge of public health services until she was taken ill in January, 1947.

Edith Miller, who graduated from the Brantford General Hospital, Ont., in 1921, died recently. Miss Miller had worked as a school nurse and later as registrar of nurses.

Clara May (Hood) Morrison, who graduated from the Winnipeg General Hospital in 1901, died suddenly on April 28, 1948, in Winnipeg, at the age of seventy-three. During World War I, Mrs. Morrison saw service in England and France, serving with the armed forces for seven years. She was decorated with the Royal Red Cross. During her long years of private duty nursing she was twice president of the Manitoba Association of Registered Nurses, and at the time of her death was a member of the Winnipeg Children's Aid Society. She had also been active in her alumnae association.

Aileen Charlotte (Reid) Sanrud, a graduate of the Regina Grey Nuns' Hospital, died suddenly at her home in Moose Jaw on April 5, 1948, at the age of thirty.

Emmeline (Ferguson) Somerville, who graduated from a school of nursing in Toronto, died in Guelph on April 18, 1948, after an illness of two months. Mrs. Somerville was for many years on the staff of the Groves Memorial Hospital, Fergus, Ont.

Charlotte Elizabeth Storey, who had served as a nursing sister at Ste. Anne de Bellevue Hospital, Que., for the past twenty-six years, passed away suddenly on April 23, 1948, at the age of sixty-eight. Miss Storey was one of the contributors on psychiatry in the preparation of "Three Centuries of Canadian Nursing."

The Nurse's Ideal Shoe

South African nurses are expressing their gratitude to the Physiotherapy Department of the Frere Hospital at East London, S.A., for its energetic protest against what it has termed the unsuitable shoes supplied to that hospital's nursing staff. In a report to the medical superintendent, the department declared that much of the foot trouble suffered by the nurses might be avoided were they supplied with a better designed shoe. The defects specified were: insufficient support under the instep; heel too high; a too-rounded inner border of the shoe.

The characteristics which the nurse's ideal shoe should have, according to the Physiotherapy Department, are: adequate support for the instep; a broad, low heel; good quality leather, capable of maintaining the shape of the shoe; and a close fit round the ankle.

The Hospital Board has taken the matter up with the authorities concerned. Meanwhile virtually every hospital staff in the Dominion is examining its shoe situation, with a view to getting the right foot-wear, should there be dissatisfaction with what has hitherto been available.

— *The British Journal of Nursing*

Neglected children cost more than well-nourished ones to everybody except their immediate parents.— G. B. Shaw

Notes from National Office

Across the Desk in National Office

Many letters, many articles, many bits and pieces of information gleaned from here, there, and everywhere cross over the desk in National Office. Whenever possible this information is shared with all our members. Extracts are taken from press clippings which number five to six hundred per month. These are mimeographed and sent to all provincial associations in sufficient numbers for distribution among the chapters and districts. In this way it is hoped that nurses may have some idea of public utterances concerning nurses and nursing.

This month we propose, through the medium of these Notes, to share information gleaned from news, letters, reports, etc., received from various international nursing organizations.

Britain

The Royal College of Nursing in Britain, in their notes on council meetings and reporting on problems of national insurance, has this to say:

The position of private nurses under the National Insurance Act has been partially clarified, since the question of whether they should be classed as employees or as self employed will depend, not, as heretofore, on their contract of service, but on their method of employment and the source of their remuneration. If a private nurse works on her own and collects her own fees, she will fall into Class II (Self Employed) which gives no cover against unemployment and industrial injury; if, on the other hand, she is on the staff of a nurse supply agency or co-operation itself responsible for collecting the fees (and deducting commission), the private nurse will be regarded as an employee and placed in Class I. In this connection it should be noted that for contributors who transfer from Class II to Class I there is a qualifying period of thirteen weeks before benefit can be claimed. The position would, on this basis, be comparatively straightforward but for the fact that the majority of co-operations — especially those run as strictly commercial undertakings — expect their nurses to collect their own fees. Council is, therefore, seeking an opportunity of discussing these points with the National Insurance Advisory Committee.

The council of the Royal College has nominated Miss K. F. Armstrong, until recently editor of the *Nursing Times*, as president of the National Council of Nurses for Britain, a position which has become vacant owing to the appointment of Miss D. C. Bridges as executive secretary, International Council of Nurses. The National Council of Nurses has sent out a questionnaire regarding its future constitution and functions. One of the branches of the Royal College in reply has suggested that the National Council be asked to make an independent study of the nursing organizations in Britain on lines similar to studies recently carried out by the American Nurses' Association and the Florence Nightingale International Foundation, with a view to determining the proper functions of such organizations and the extent to which the functions were fulfilled; also to make suggestions as to how British nurses might be represented on the International Council of Nurses without duplication of representation and over-complexity of administration.

United States Army Nurse Corps

From the office of the Surgeon General, Washington, D.C., comes the following report of the Army Nurse Corps for the fiscal years, 1946-48:

The peak strength of the U.S. Army

Nurse Corps during World War II was 57,000. Although a total of 62,000 nurses were ordered to active duty during the period from 1940 to 1943, 57,000 were on duty simultaneously. Approximately one thousand vacancies exist in the Army Nurse Corps at this date. Existing and future vacancies in the Army Nurse Corps must be filled by qualified nurses who are members of the Reserve Corps. It is expected that the opportunity for applications for regular army will be given in early 1949 to members of the Reserve under the age of twenty-eight who have demonstrated their adaptability to military service through a tour of extended active duty.

The authorized strength of the Army Nurse Corps, Regular Army, was in a ratio of six members thereof to each thousand persons of the total authorized strength of the Regular Army, but not less than a minimum authorized strength of 2,558 members.

At the present time the educational program for Army nurses offers the following courses: psychiatric nursing, 6 months; anesthesiology, 13 months; hospital and nursing administration, 4 months; operating-room technique and management, 6 months; basic military course, 8 weeks, and nursing education at a recognized university for a period of one academic year.

To be eligible for all courses conducted by the Army, an Army nurse must be in one of the following categories:

(a) A member of the Regular Army.

(b) Member of the Officers' Reserve Corps who has signed a statement of intention of remaining on extended active duty for a period of two years after completion of the course concerned.

An average of one hundred nurses is enrolled at all times in courses ranging from four to thirteen months in length.

A committee of nurses developed a manual of nursing procedures in an effort to standardize procedures in Army hospitals. One hundred test copies were sent to the field for suggestions and improvements, inclusion or deletion of certain procedures, and evaluation of publication for distribution to all medical installations. This book was very favorably received in the field and recommended for publication as a standard guide for nursing procedures in Army hospitals. After these comments are reviewed it is planned that the book will be put in final printed loose-leaf form and sufficient copies made available to supply each ward of every Army hospital with a copy.

National League of Nursing Education

The Committee on Public Relations of the National League of Nursing Education in the United States now issues a League Letter to all its members. Two of these letters have recently come to our desk — one entitled "About the School of Nursing Study: a Fact Sheet," the second, "Student Recruitment — Our Responsibility."

The following is a brief summary of the Fact Sheet on the School of Nursing Study:

This study was undertaken as an investigation of the present patterns of administration, organization, and financing of schools of nursing. In the course of the investigation the study has sought to clarify the role of the nurse in the future, the preparation she would need for that role, and the adjustments that may be needed in administering and financing her education.

The National Nursing Council, representing all national professional nursing organizations and allied agencies providing nursing service, is the sponsor. The Carnegie Corporation of New York provided funds for the study. Esther Lucile Brown, Ph.D., of the Russell Sage Foundation, was released to direct the study. A professional advisory committee of nurses has kept in close touch with developments.

A lay advisory committee represents the viewpoints of the community.

Some of the reasons for the study: Social and economic changes, beginning, before the war, intensified by it; widespread and insistent demand by public for nursing service; new responsibilities assigned by medical, hospital, and public health practitioners, for which too

few nurses were equipped; wartime revelation of inadequacies; dissatisfaction of nurses with present system; vast increase in hospital facilities; growth of newer concepts of health and of education.

Three conferences were held to offer Dr. Brown a wider basis of consultation than field visits permitted. Washington, San Francisco, and Chicago were the centres chosen for the conferences. More than a thousand persons attended them. All schools were invited to send representatives. Participants came from schools with diploma programs and with degree programs. Also participating were hospital administrators, college presidents, deans of women, public health nursing administrators, state boards, non-nurse educators, and others.

A report of these conferences, entitled "A Thousand Think Together," has recently been published and received in National Office. We recommend the study of this volume to all who are concerned with nursing education. When Dr. Brown undertook to make the study it was agreed that she would be free, as a trained observer, to explore professional nursing of today and tomorrow and to recommend the types of educational pattern which will produce the kinds of nurses needed, "without regard to the desires of any vested interest, including that of the nurses themselves." Instead of seeking to tie her down with strings from organizations hoping to maintain the *status quo*, the committee granted her an independent approach, the only one she would accept. Her recommendations, though based on consultations and co-operation with many others, will be hers alone. As a representative of the public rather than of nursing, her conclusions are expected to be based on her own convictions about what society needs from nursing.

The public and the nursing profession await with keen interest the final report of this timely study which Dr. Brown presented to the biennial convention of the American Nurses' Association in Chicago.

Student Recruitment

The American Hospital Association has for the past eighteen months carried an extremely active recruitment program for student nurses in the U.S. This association, however, now plans to discontinue the program at the end of this year. During 1947, the number of admissions to schools of nursing in the U.S. increased about ten thousand over the previous year. Nursing organizations are now planning ways and means for the continuation of a recruitment program.

Notes du Secrétariat de l'A. I. C.

Au secrétariat national, des nouvelles, des renseignements, des rapports nous parviennent de tous côtés. Lorsqu'ils sont susceptibles d'intéresser nos membres, nous essayons de les renseigner soit par l'entremise des notes du secrétariat ou encore en faisant parvenir aux associations provinciales, des copies d'extraits de journaux, qui sont distribuées aux chefs de groupes d'infirmières.

GRANDE-BRETAGNE: Le Collège Royal des Infirmières de Grande-Bretagne nous a fait parvenir le communiqué suivant concernant *le plan national des assurances sociales* et les infirmières du service privé:

En Angleterre les infirmières travaillent à leur propre compte (classe II) ou elles sont employées par une agence qui leur donne un salaire régulier (classe I).

Les infirmières du service privé seront classifiées dans le plan des assurances nationales comme employées ou comme leur propre employeur, selon le contrat de service qu'elles ont et selon la provenance de leurs honoraires.

Si une infirmière travaille à son propre compte et perçoit elle-même ses honoraires, elle fera partie de la classe II et elle n'aura droit ni à l'assurance-chômage, ni aux assu-

rances de la Commission du Travail; si, d'autre part, l'infirmière du service privé est employée par une agence ou une institution qui perçoit pour elle les honoraires dues par les malades dont elle a été à l'emploi, elle fera partie de la classe I.

Si une infirmière passe de la classe II à la classe I, durant une période de treize semaines, elle ne sera pas éligible aux bénéfices des assurances.

Il existe encore un malentendu du fait d'un grand nombre d'infirmières appartient à des agences, registres qui donnent les cas aux infirmières, mais qui laissent à ces dernières la charge de percevoir leurs honoraires.

Le conseil des infirmières doit discuter ce point avec un comité d'aviseurs des assurances nationales.

L'éditrice précédente du *Nursing Times* (magazine professionnel), Mlle K. F. Armstrong, a été élue présidente du Conseil des Infirmières de Grande-Bretagne.

ETATS-UNIS D'AMÉRIQUE — INFIRMIÈRES DE L'ARMÉE: Des bureaux du Chirurgien Général à Washington, D.C., le rapport suivant nous est parvenu concernant les infirmières de l'armée pour les années 1946-48:

Durant la 2e guerre mondiale, le plus grand nombre d'infirmières enrolées de 1940 à 1943 fut de 62,000 mais de ce nombre il n'y en a eu que 57,000 employées à la fois.

Les cadres du corps des infirmières comptent actuellement 1,000 vacances. Les infirmières qualifiées faisant partie de l'Armée de Réserve sont les candidates toutes désignées pour remplir les cadres de l'Armée Active. La limite d'âge est de 28 ans.

D'après les règlements de l'armée, le corps des infirmières doit se composer de 6 infirmières pour chaque mille hommes de l'armée régulière et au minimum de 2,558 infirmières.

Actuellement le programme d'étude des infirmières de l'armée est le suivant: Cours de nursing en psychiatrie, 6 mois; anesthésie, 13 mois; administration hospitalière, 4 mois; administration et technique aux salles d'opération, 6 mois; cours spéciaux aux infirmières militaires, 8 semaines; cours universitaire en nursing d'une année. Une moyenne de 100 infirmières suivent ces cours.

Pour être éligible à l'admission de ces cours, l'infirmière doit: (a) appartenir à l'armée régulière; (b) être officier de l'Armée de Réserve et s'engager d'y demeurer durant deux années, après avoir complété le cours.

NATIONAL LEAGUE OF NURSING EDUCATION, U.S.A.: Le Comité des Relations Extérieures de la Ligue envoie maintenant une lettre à chacun de ses membres, les deux suivantes nous sont parvenues: "Une Etude sur les Ecoles d'Infirmières"; "Le Recrutement des Elèves-infirmières — nos Responsabilités."

La première lettre rapporte les faits trouvés lors de l'enquête faite dans le but de trouver quels seraient les besoins de l'infirmière de l'avenir, la préparation qu'il conviendrait de lui donner pour qu'elle puisse remplir le rôle qu'elle aura à jouer, etc.

Les raisons qui ont motivé cette enquête sont: les changements sociaux et économiques depuis la guerre; la demande toujours croissante du public des services de l'infirmière; les devoirs nouveaux chargés de responsabilités confiés aux infirmières par les hôpitaux, les médecins, et les agences de santé et devoirs pour lesquels trop peu d'infirmières sont préparées; le mécontentement exprimé par les infirmières sur les cours d'infirmières; les facilités d'hospitalisation; l'éducation du public en matière d'hygiène.

Un livre intitulé "Mille Pensent de la Même Façon" a été reçu. Il contient une série de conférences. Il est à recommander à toutes celles qui s'occupent de la formation d'infirmière.

RECRUTEMENT DES INFIRMIÈRES: "L'American Hospital Association" a durant les derniers 18 mois organisé une campagne de recrutement très active dans le but d'augmenter le nombre des élèves-infirmières. Durant 1947, dix milles candidates se sont inscrites aux écoles d'infirmières.

A New Rodenticide

Investigation has shown that Castrix, a new rodenticide, is about five times more toxic to rats than the wartime discoveries known as 1080 and ANTU. It is readily acceptable to rats and highly toxic when offered at a concentration of 1 per cent in the diet. Castrix produces convulsions and death in about thirty minutes after lethal doses are eaten. Sodium pentobarbital (Nembutal) was found to be a very effective antidote for Castrix poisoning.

— *Canadian Pharmaceutical Journal*

STUDENT NURSES PAGE

Tick Paralysis

MARGARET FORD

A PATIENT with a rare condition was admitted to our hospital. She was a four-year-old Japanese girl. Her anxious mother said that the child had fallen from a table two days previously. She did not appear to hurt herself, she was not unconscious, nor did she complain of any pain. That evening her parents observed that she did not walk normally and the next day could not walk at all. Alarmed, her parents brought her to hospital that afternoon.

In hospital the child was examined by the doctor. She could move her arms and legs when lying on her back, but lacked complete control of them and the movements were weak. When put on her feet she had no muscular control and could not stand at all. Further examination revealed no abnormality of reflexes, no neck rigidity or Kernig's sign (a sign of meningitis). She did not complain of any pain or tenderness. The child did not look ill. On continuing the examination a large, engorged wood tick was found embedded in the occipital region of the scalp. This was the cause of the illness.

Tick paralysis, as observed in the Rocky Mountain region, is an acute ascending motor paralysis, caused by the bite of certain female wood ticks. The etiology is unknown but it is generally considered to be due to a toxin injected by these ticks. This has not been proved. It occurs in the spring when the ticks are most active, infesting grass and shrubbery. It is most frequently met with in children, especially girls, because the tick, embedded in the scalp, is not noticed due to the long hair. Tick paralysis in an adult is less frequent, probably due to the fact that an adult is more likely to find and remove the attached tick. There is evidence also which indicates that persons of mature age are more resistant.

The onset is usually sudden, and in an affected child the first suspicious sign is a weaving, wobbly, or staggering gait. In a short time the child is unable to stand. Sometimes the onset is less rapid and is accompanied by nervousness, weakness and, infrequently, by pain in the lower limbs, back, or abdomen. Usually the temperature remains normal. Convulsions or vomiting occur in occasional cases. Vertigo is common. The paralysis progresses rapidly and the throat and respiratory muscles are soon involved. Phonation becomes difficult and finally impossible. Breathing becomes rapid, often labored, and the patient becomes stuporous. There is inability to swallow, the tongue becomes swollen and protruding, and death from respiratory paralysis follows in three to five days; in rare cases it may occur in less than twenty-four hours.

If the tick is removed before the respiratory and heart muscles are in-

Miss Ford is a student nurse at the school of nursing of the Royal Inland Hospital, Kamloops, B.C.

volved, improvement is common in thirty minutes to one hour; complete recovery follows in one to five days, depending apparently upon the degree of paralysis at the time of tick removal. The paralysis recedes in the reverse order to its progression, remaining longest in the feet. Paralysis is confined to the nerves governing movement and does not affect the special senses.

Ticks causing paralysis may be attached to any portion of the body. They are most often found on the head, usually at the back of the neck, but have also been reported in the axillae and groin. Paralysis has never been reported when the tick was attached to the legs.

Methods often used to remove a tick are kerosene, gasoline, oil, ether, gentle traction, and heat. Iodine, silver nitrate pencil, or some other antiseptic agent should be applied to the site of the bite. In this case the doctor excised the wood tick with the involved skin, under a local anesthetic. That night the child lay quietly. She was still unable to move her arms or legs. Next morning her condition was slightly improved, though arms and legs were still limp. Late that afternoon she stood up with the help of the crib. The next day she was playing happily in her crib, banging the bars and walking about the small area. After examination she was discharged. Her parents, very relieved, welcomed the child and the "cause," carefully bottled.

Every year reports come in of animals which are afflicted with tick paralysis displaying the same clinical symptoms as humans. Sheep and cattle are most commonly affected. This condition has been confused with Landry's disease and poliomyelitis.

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Manitoba Student Nurses' Association

This association was formed in November, 1944. It has travelled along the pioneer road of adventure, overcoming many of the difficult growing pains and is now, in 1948, settled on a sound foundation, slowly climbing the ladder to new and greater heights of recognition and success.

The purpose behind the formation of this association was to secure official representation of student nurses; to keep students informed of special events in the world of nursing; to broaden their cultural background; and to provide a means of friendly contact with student nurses in all parts of the province. They obtain money from an annual fee of ten cents per student nurse, the amount not to exceed twenty-five dollars from each individual hospital. The fee usually comes from the student government funds as the student is not earning.

The association has made the student nurses realize that they have common interests and problems and has enlarged their circle of friends, making them interested in the other schools of nursing in the province. It has brought a feeling of fellowship among them and has provided a means of entertainment, which is greatly appreciated by every one of the students, especially those from out of Winnipeg.

In order for the M.S.N.A. to function and progress, it is necessary that the nurses lend their support and interest. To accomplish this, the enthusiasm of the executive is essential. They in turn plan meetings which will be of interest and help to the students.

There has been a great deal of controversy as to what to do with the money raised for a scholarship fund. The idea of a Student Nurses' Loan Fund was tentatively suggested,

but it did not meet with the approval of the students as a whole, as shown by a vote. Therefore, the final decision was for the M.S.N.A. to give one or more scholarships each year, the amount to be decided annually by the executive, to the student or students receiving the highest marks in her registered nurses' examinations.

Features of the association that have developed since the formation are the M.S.N.A. pin, the annual banquet at which there is an exchange of officers, the annual dance held to raise funds, sports night at the Y.W.C.A. where the students may participate in gymnastics and swimming once a week, and a scholarship fund. This year a representative of the M.S.N.A. was sent to the C.N.A. convention at Sackville, N.B.

There is a mass meeting of all members once a month. The ever-present time limit is a problem at these meetings. It is impossible to start before 8:00 p.m. because of the nurses who work until 7:00 p.m. and the meetings must close at 9:30 p.m. in order to return by 10:00 p.m. However, the superintendents of nurses have been very cooperative in granting the students special late leave privileges for the various mass meetings, which is greatly appreciated by them all.

Approximately ten days prior to the mass meeting, the executive meeting is held where business of the association is discussed and the forthcoming mass meeting is planned. Posters are put up in each school announcing the mass meeting and giving the details. A small lunch is served at the close of the mass meetings. In order to overcome some of the expenses of this lunch, tickets are sold for a door prize, usually nylons. This has proven very successful.

The Sports Committee has done an excellent job in maintaining the enthusiasm of the students who have been present at weekly workouts at the "Y". After a hard day's work on wards, often with extra hours spent in classrooms, a soft bed seems much more inviting than a trip to Sports Night. However, once the students have crawled to the "Y," and limbered up with exercising, marching, games, dancing (folk, square, and ballroom), and then plunged into the pool for forty-five minutes, they almost feel like doing a day's work there and then. The instructors have been very helpful in teaching swimming and diving. The Sports Committee planned a swimming gala for the spring.

Home talent programs have been very worthwhile. There is a great deal of hidden talent among the student nurses and these meetings are a means of discovering musicians, dramatists, comedians, etc.

One of the major difficulties has been arranging executive and committee meetings when the girls are working on different shifts. Each hospital has its own hours and it is an impossibility to have every member present at a meeting. However, there are always enough nurses to make each meeting a successful one.

The student nurses are greatly indebted to the superintendents of nurses of each school of nursing. They have been keenly interested in the work done by the association and have assisted greatly in several instances. They have given permission to hold mass meetings in the various hospitals and nurses' homes and have been very lenient in granting late leaves. The type of meeting determines the hour of return. Miss F. Waugh, who is the adviser for the association, has been invaluable with her wisdom, experience, and guidance. Without her, the association might not have been able to climb those perilous steps.

The student or students receiving the highest marks in the registered nurses' examinations will receive her money at the annual banquet held in June. The retiring president exchanges a bracelet with the new president. This banquet provides an excellent opportunity for the nurses from out of town to be present. They bring a report of the year's activities and progress in their own school. It has always proved very interesting.

The Manitoba Student Nurses' Association was the first organization of this kind in Canada and the future looks very promising. However, success can only be ours with the help and support of every Manitoba student nurse. It has been a great pleasure for me to be president of this association for 1947-48 and I would like to take this opportunity to thank the nurses for their interest and enthusiasm.

BETTY BALDNER
President

If you want to be original, you must not read too much.— ANON

Athlete's Foot

Dermatophytosis pedia, commonly known as athlete's foot, is an inflammatory, contagious, cutaneous disease of the feet which may affect the hands both as a direct infection and in the form of "ids." There are three types: vesicular, hyperkeratotic, and intertriginous. Fungi may cause approximately 50 per cent of these conditions but it is possible that bacteria and sensitization are responsible for some cases. The important predisposing factor appears to be improper hygiene of the feet. Women are less frequently affected than men with this condition and it is more common in summer than in winter.

The vesicular type is first observed as a deep-seated, slightly elevated vesicle containing a clear fluid with no surrounding edema. Absorption of the fluid takes place in a few days and a brownish crusted and scaly macule results. The vesicles occur on the ventral surface of the toes, spreading to the under side of the arch and eventually covering the entire sole. Burning and itching accompany these vesicles and relief may be provided by opening the lesions and removing the fluid. Secondary infection may develop in these vesicles if they are allowed to progress without therapy.

In the hyperkeratotic type, the skin develops an erythema and eventually becomes thickened and scaly. This type occurs more frequently on the soles and sides of the foot.

The most common type is the intertriginous which usually begins as a fissure at the base of the fifth toe and may spread to the other interdigital webs. In some cases only scaling may be observed in which instances fungi may not be present. Pruritus may be slight, severe, or absent.

It is important to establish that the condition is not due to contact dermatitis. Diagnosis is made on the basis of microscopic examination of skin scrapings from the affected area. Shoe polish, fungicides, antiseptics, dye from stockings, etc., may cause a contact dermatitis which usually occurs on the skin of the dorsum of the foot, rarely on the sole.

Prophylaxis is most important, both in preventing initial attacks and recurrence. This is directed at adequate care of the feet rather than the environment. The first point in treatment is to establish a definite technique for sterilization of shoes. Leather limits the possibilities. Gases are preferable to liquids but formaldehyde vapor does not penetrate satisfactorily into the cracks. The simplest way to clean up a few pairs of shoes is to remove extraneous dirt with mild soap and water. After drying as well as possible, spread a pad of cotton inside to make an insole. Pour onto this insole a teaspoonful of a 1:10 solution of formaldehyde. Place the shoes in a box and wrap it securely in paper, leaving it so wrapped for six hours. Afterwards, air the shoes for twenty-four hours.

Wearing of sandals has been found to be of value since they allow for aeration, prevent accumulation of sweat, and permit free movement of the toes. Good cutaneous circulation is thus favored.

The ointment or dusting powder to be used in treatment will be prescribed by the physician. Immersion of the feet for one hour in a 1 per cent freshly prepared solution of sodium hypochlorite may serve to prevent the infection when exposure has taken place.

— Abstracted from *Medical Times*, May, 1948

I.C.N. Congress, 1949

The following information has been received from Miss Gerda Höjer, president, I.C.N., concerning admission to the International Congress to be held in Stockholm, Sweden, in June, 1949: "Any nurse wishing to attend the I.C.N. Congress in Stockholm, June, 1949, must produce evidence of membership in her national association which is a member of I.C.N." The Canadian Nurses' Association is our member association. Your receipt for current membership in your provincial registered nurses' association, which automatically includes membership in our national association, is the "evidence of membership" which will be required.

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Book Reviews

Theory of Occupational Therapy, by Norah A. Haworth, M.A., M.R.C.S., L.R.C.P., D.P.M. and E. Mary Macdonald. 158 pages. Published by Baillière, Tindall & Cox, London, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 3rd Ed. 1946. Illustrated. Price $1.75.

Reviewed by Muriel F. Driver, Occupational Therapist, Runnymede Hospital, Toronto.

This concise textbook on occupational therapy covers the basic principles of occupational therapy treatment and its uses in the various fields of medicine. The chapter entitled Rehabilitation in Industry shows the importance of occupational therapy on the treatment of industrial casualties and the wide scope for development offered to workers in this branch of medicine.

Clear diagrams of equipment and adaptations for specific treatment purposes are included. Lists of materials and discussion of administrative details should be of great value to a therapist, particularly when establishing a new department.

This book deals with the various aspects of treatment in a very general manner. However, this should prove very helpful to a therapist when preparing lecture material for student nurses or staff discussion groups. To the members of the medical and nursing staff this text presents a clear picture of a treatment program designed to complement their medical and nursing care.

Pamphlets that Pull, by Alexander L. Crosby. 32 pages. Published by the National Publicity Council, 130 East 22nd St., New York City 10. 1948. Illustrated. Price (in U.S.A.) $1.00. (Reduced rates for orders of 10 or more copies.)

Every organized group has occasions when it wishes to publish pamphlets. Perhaps it is the school of nursing calendar or a public health organization's annual report, or a tool in a publicity campaign to raise money. Preparing pamphlets is a specialized piece of work that requires skill, knowledge, and a flair for the use of words. To supply the "know-how" of this interesting form of public relations, the author cites numerous illustrations for each step in the process. A useful and valuable tool for every nursing director to possess.

Modern Urology for Nurses, by Sheila M. Dwyer, R.N., B.S. and George W. Fish, M.D. 287 pages. Published by Lea & Febiger, Philadelphia. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1945. Illustrated. Price $3.25.

Reviewed by Lila A. Ellis, Supervisor, Urology Ward, Royal Victoria Hospital, Montreal.

In this nursing manual, the authors have given both graduate and student nurses a concise, accurate, and interesting description of urological procedures, and the nursing care involved. The chapters on urethral instruments, cleaning and sterilization, urological examination and nursing care, with the accompanying illustrations, are excellent for teaching programs.

The post-operative care of all urological operations is outlined in a simple yet thorough manner. Emphasis is placed on nursing the patient following prostatectomy, with description of complications which may be expected, and their proper treatment.

The nursing care of non-operative urological cases is also fully discussed. The chapters on cystoscopic instruments and procedures and operating-room procedures are excellent. The final chapter deals with a teaching program for urology. Good pre- and post-operative nursing care is essential in the successful outcome of urological surgery. This is due in great part to the preponderance of patients in the older age groups with the likelihood of complications, and the long convalescence which usually follows operations in this specialty.

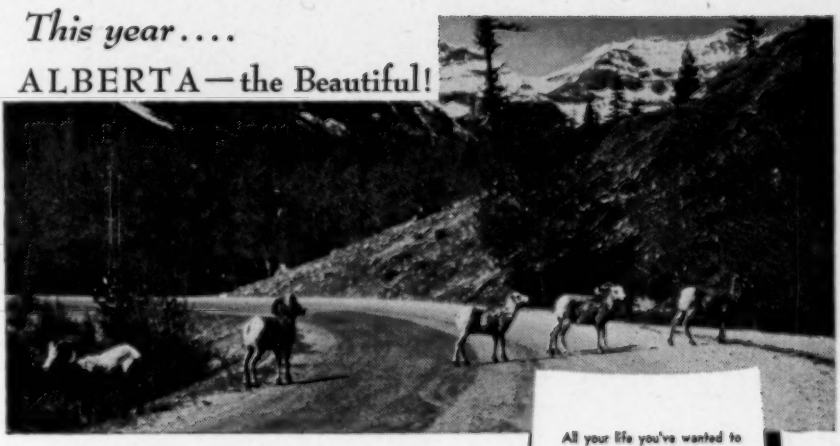
This small, concise textbook is an important addition to the literature on urological nursing, and provides an excellent reference in this specialty.

Life would be a perpetual flea hunt if a man were obliged to run down all the innuendoes, inveracities, insinuations, and misrepresentations which are uttered against him.

— Henry Ward Beecher

This year....

ALBERTA—the Beautiful!



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Indirect contact is through towels or dishes catching a disease.

In a scarlet fever patient, nose and throat secretions should be collected in a bag.

Patients should be lifted in one piece. The nurse should never attempt it alone.

The uterus is a muscular organ that sits on the bladder.

Cheyne-Stokes respirations mean that the patient has died.

In passing a nasal tube, listen for the glug.

The three basic shapes of bacteria are rods, berries, and crooked lines.

Daily bowels are necessary for health.

Mother to district nurse: "I don't know what I'm going to do with that girl, nurse. She is that collapsible!"

Leeuwenhoek is noted in bacteriology because he completed the first red blood cell count.

News Notes

ALBERTA

CALGARY:

Fifty-four members of the 1948 class received their pins and diplomas from Mayor Watson at the fiftieth graduation ceremony of the Calgary General Hospital School of Nursing. Mr. D. B. MacKenzie, chairman of the Calgary Hospital Board, spoke to the graduates and Dr. R. G. Townsend gave the address to the new graduates. Rae Chittick, a member of the Faculty of Education at the University of Alberta, and past president of the C.N.A., led the Nightingale Pledge. The benediction was given by Rev. Dr. Frank S. Morley. Laura Edwards, valedictorian, was presented with a gift by Dr. Morley on behalf of the congregation of Grace Presbyterian Church.

Prize winners included: Peggy Saunders, $200 scholarship for highest standing in theory; Jean Hambling, gold medal for gen-

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eral proficiency; Signe Vesterdal, silver medal for proficiency; Dorothy Harbidge, Pattison Memorial Medal for obstetrical nursing; Laura Edwards, Dr. H. A. Gibson prize as the graduate who, by a vote of her classmates, was the most influential in preserving the ideals and ethics of her class during her three years' training; Isabelle MacKenzie, prize donated by Alberta Pharmaceutical Association for highest standing in pharmacology; Dorothy Barker, award presented by alumnae association for surgical technique; Elizabeth Groeneveld, prize awarded by Ladies Auxiliary for medical nursing; Vida McMillan, prize presented by W. J. Edwards for sterilizing technique.

The alumnae association celebrated its fiftieth anniversary at a banquet in honor of the class of 1948. Commemorating the occasion, the alumnae presented the Hospital Board with a cheque for $1,000 and a resuscitator in acknowledgement and appreciation of the work carried on by the hospital, one of Calgary's oldest public service institutions. The donation will go towards the new hospital which is contemplated.

Mrs. A. E. Wilson, the alumnae president, welcomed the new graduates, followed by the candlelighting ceremony in which a past graduate passes on to the new graduate a light from her candle, symbolizing the passing of the torch of service from those who have gone before. Mrs. Ned Hall led the ceremony, lighting the first candle.

Three hundred and thirty-one members attended the banquet, an all-time high, fifty being from out of town, including Louise Arnold of Santa Barbara, Calif., and Ethel Annabelle of Roseburg, Oregon — 1924 graduates. A solo was sung by Jean McFarlane. Appreciation was extended to Mrs. J. J. Porter, who convened the banquet, and to Mrs. T. L. O'Keefe who wrote and directed the humorous skit "Do you Remember." The class president, Miss Edwards, extended the thanks of the graduates to the alumnae for the banquet in their honor.

LAMONT:

Sixty-four members and guests were present at the luncheon given by the Lamont Public Hospital School of Nursing Alumnae Association in honor of the class of 1948. Among those present were members of the hospital and medical faculty and their wives, and the Rev. and Mrs. Kirk. A year's subscription to *The Canadian Nurse*, accompanied by a yellow rose, was presented by I. Feenie to each member of the class. Mrs. Ringwood, who entertained the party with an original reading on "Alberta," was presented with a corsage of gardenias by Mrs. J. L. Cleary. Mrs. Cooper, superintendent of nurses, who has been closely associated with the alumnae association in her capacity as news editor, and who leaves for the U.S.A., was also presented with a corsage by Mrs. A. Cowan.

MEDICINE HAT:

The Medicine Hat School of Nursing Alumnae Association recently held a tea, dinner and

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dance for the 1948 graduating class of thirteen nurses. The nurses' residence was the scene of the tea for out-of-town guests, members of the alumnae, and relatives of the 1948 class. Conveners were Mmes Goldie and Dederer. Guests were also shown around the hospital.

Seventy-one were in attendance at the dinner held for the graduates. The toast to the King was proposed by the alumnae president, Mary Rowles, while that to the graduating class was given by Mrs. A. Dewald, responded to by H. Shimbaski. I. Misener, superintendent of nurses, introduced the new graduates, and the toast to the school of nursing was given by Mrs. T. Graham, responded to by M. Danan. It was interesting to note that graduates over a period of forty years were present, including Mrs. John Hall, a member of the class of 1908. The convener for the dinner was Mrs. L. Garrett, Mrs. D. Fawcett being responsible for the attractive place cards.

The graduation dance, sponsored by the board of directors and the alumnae, was held following the dinner. Guests were received by I. Misener, superintendent of nurses; M. Rowles, alumnae president; and Mrs. John Hill, the alumnae's honorary president.

BRITISH COLUMBIA

CHILLIWACK:

Around one hundred members were present at the district meeting of Fraser Valley held in Chilliwack, representing New Westminster, Haney, Mission, Abbotsford, and Chilliwack. At the conclusion of business a social evening was held when each chapter gave a short skit.

At a recent meeting of Chilliwack Chapter about thirty members attended. Dr. J. Sparks, of the Crippled Children's Hospital, Vancouver, gave an interesting illustrated lecture. Two piano solos were rendered by Edgar Toop.

TRAIL:

Alice Wright, executive secretary, R.N. A.B.C., was the guest speaker at a meeting of Trail Chapter when she spoke on the resolutions passed at the annual meeting of the provincial association and of the program for the coming year. She outlined the new course for training practical nurses at the Vancouver Technical College and General Hospital. Miss Wright was introduced by Mrs. Gavrilik. Another interesting feature of the meeting was the paper on new developments in early diagnosis of cancer and further developments in the study of the Rh factor in the new-born given by Dr. R. H. Christie.

VANCOUVER:

St. Paul's Hospital:

A new Auxiliary Group has been formed in the Fairview district and all S.P.H. alumnae in that district are invited to attend the meetings. A Spring Tea was held by the Dunbar Auxiliary Group. The conveners were Mmes

McRae and Edgett, assisted by Mmes Large, Collishaw, and Deshaw. A door prize and candy sale (Mrs. Dawe's specialty) were features of the event. The proceeds went towards the Bursary Fund and the social service projects of the group.

The bowling season is over with Maternity the victorious team. The end of the season was celebrated by a dinner at the Quadra Club on May 27. The sports committee reports that the Riding Club is resuming activities. One or two of our venturesome members took spills recently. Fortunately, injuries were not serious.

A hearty "thank you" goes to Mrs. McOuat, the retiring registrar, for her services during the past two years. Fourth North has said goodbye to J. Black who has returned to her home at Powell River. L. Fisher has left on a trip to Scotland. Mr. and Mrs. H. (Carton) Horne sail for Oslo, Norway, to make their home. Mary Dowie, who is doing public health work in the Peace River District, was a recent visitor. Miss Kunderman will further her studies in New York. Rusty Davis, after five years as assistant matron at Coqualeetza Indian Hospital, Sardis, has been transferred to Miller Bay Indian Hospital, Prince Rupert, as matron. Lorna Richmond has also joined the Miller Bay hospital staff.

VICTORIA:

Mr. G. Rudge, probation officer for the Juvenile Court, was guest speaker at a recent meeting of Victoria Chapter, R.N.A.B.C. He told of the organization and purpose of this branch of child welfare. The program was demonstrated by a film entitled "Boy in Court."

Royal Jubilee Hospital:

The alumnae held a tea in honor of the members of the class of 1948. The rummage sale, convened by D. Gifford, proved a successful alumnae project.

St. Joseph's Hospital:

The alumnae association recently entertained at a reception and dance in honor of the new graduating class.

MANITOBA

BRANDON:

The graduating classes of the Brandon Mental and General hospitals were honored guests at the thirty-first annual dinner and dance held recently by the Association of Graduate Nurses. The guest speaker, Mrs. M. F. Cannon, counselled all present to carry on in their noble profession, the reward being rich in the remembrance of having made the world a better place to live in.

A business meeting followed the dinner, presided over by the president, Marion Patterson. Reports from the various conveners were given, summing up a successful year's activities. Congratulations to the graduating nurses were expressed by Agnes Crighton and

Wards miles long? Midday find you trudging from bed to bed? Ache to get off your feet? Chances are you, too, are suffering from "tireditis" common to business gals of all stations.

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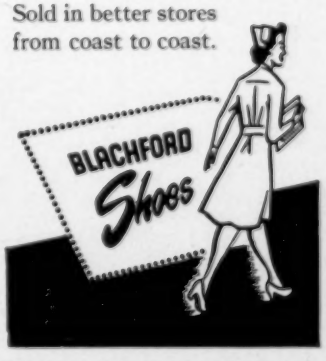

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replied to by Beverly Ilott. A highlight of the evening was the presentation of a $500 scholarship, sponsored by the association, to Alma Floyd, a member of the 1948 class of the General Hospital, for post-graduate studies at the McGill School for Graduate Nurses. The presentation of life membership was made to Margaret Gammell, Mmes S. J. S. Peirce and Persis Darrach, O.B.E., in appreciation of their contribution to the nursing profession and good citizenship. Congratulations were expressed to Mrs. J. Esslemont on the occasion of her diamond wedding anniversary.

Caroline Wedderburn will serve as president for the coming year, with Mrs. E. Griffin as vice-president. The secretary is Jean Mitchell, treasurer, Mrs. Ruth Brown, and Mrs. M. McNee will continue as press representative.

General Hospital:

Fifteen nurses received their diplomas at the graduation exercises of the Brandon General Hospital School of Nursing, when three scholarship awards of $150 each were made. L. Arnott was presented with the J. R. Brodie award, B. Grigg the A. L. Kerr scholarship, and the Mabel E. Harrison award went jointly to L. Paige and D. Lewis. Other prizes were received as follows: Third year, gold medal, J. Read, who also took the Drs. H. O. and R. O. McDiarmid prize, and shared the psychiatry award given by Dr. S. Schultz. Miss Arnott was the co-winner of the latter prize as well as the bronze medal in her class. The silver medal was won by W. Birtles. G. Wolfe topped the second year and won the Reesor award, adding to her honors the Dr. H. S. Sharpe orthopedic nursing prize and the Dr. W. A. Bigelow surgical nursing award. J. Adams was best in medical nursing for an award made by the late Dr. L. J. Carter and J. Higgens was best in obstetrical nursing and received the Dr. J. A. Findlay prize. F. Amos had the highest standing in bedside nursing in a competition limited to first-year students. Dr. F. K. Purdie made this presentation while other awards were presented by Dr. G. W. J. Fiddes, medical superintendent of the hospital. F. R. Longworth, chairman, presented the scholarships, and presentation of diplomas and pins were made by Dr. Fiddes and Olive Thomas. The address to the graduates was given by D. Bruce Moorhead, principal of the Provincial Normal School, Winnipeg.

It was announced that a $50 bursary will be presented annually by the Teck Chapter, I.O.D.E., for competition only among probationers.

Mrs. R. O. McDiarmid entertained Miss Thomas, superintendent of nurses, N. Crighton, instructor, and the class of 1948 at a dinner, and Mrs. R. McBurney gave a tea for the Misses Thomas, McLeod, Crighton, and new graduates at her home when the Mmes Carter and Tackaberry assisted in serving. A mother and daughter tea was given at the nurses' residence by the intermediate class of which Sheila McClement is president. Miss Thomas and Mrs. Fiddes did the tea honors while supervisors A. Bennett, M. Green, N. Crighton, and M. Patterson assisted with the serving.

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Members of the hospital staff met at the home of Mrs. Mary Skene to honor several of their number who are leaving — Jean Wilkie, Orma McGuinness, Beverly Mummery, Mrs. Skene. Several humorous skits afforded many a laugh. Olive Thomas, Mrs. Viola Selby, and A. Bennett acted as judges and awarded first prize to R. Down's group and second to M. Patterson's group. Gifts were presented to the honored guests from those present.

Winnipeg General Hospital:

At a recent meeting of the alumnae association, very interesting reports were received from the various committees, showing an active year. The guest speaker was Jean Warren, who showed a very beautiful display of "A Pageant of Fashion" using twelve miniature mannequins. The annual reunion took the form of a dance.

NEW BRUNSWICK

SAINT JOHN:

The members of Saint John Chapter were guests of the nursing staff of the Lancaster D.V.A. Hospital at a regular meeting, with Bessie Seaman in the chair. The guest speaker was Mrs. C. E. A. Warneford who gave an informative address on "Social Services in the Community."

A large number of nurses attended the Vesper Services held at the Cathedral of the Immaculate Conception and Exmouth St. United Church.

General Hospital:

The executive of the alumnae association were guests of the president, Bea Selfridge, when final arrangements for the dinner-dance and bridge, in honor of the 1948 graduating class, were made.

All S.J.G.H. nurses, who wrote the R.N. exams, are congratulated for successfully passing. Katherine Richard, of the Moncton Hospital, led the province with Blanche Rice coming second. Constance Diggle is doing general duty at the Royal Victoria Hospital, Montreal.

ST. STEPHEN:

The graduation exercises of the Chipman Memorial Hospital School of Nursing commenced with a dinner at the St. Croix Hotel across the border in Calais, Maine. Ten nurses later received their diplomas, and a thermometer and case presented to each by the alumnae association.

Jessie Orr, C.M.H. dietitian, entertained her staff of displaced persons by taking them on a fishing trip to Porter's mill stream. Patricia Knorr, Sybil Bannister, Ethel Guptill, and Doreen Thurlow passed their registration exams, the later two now being with the N.B. Red Cross outpost hospitals.

NOVA SCOTIA

SYDNEY:

The annual graduation exercises of the City Hospital were held recently when one of the largest classes for many years received

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their diplomas and pins. Shirley Townsend was class valedictorian. Following the exercises, a reception was held when the new graduates received their friends and relatives. A private dance, sponsored by the Junior Ladies Auxiliary of the hospital, was held for the new class and hundreds of their friends enjoyed the evening. A banquet was given for the graduates by the alumnae association when Lorraine Miller, of Saskatoon, was the guest speaker. Miss Miller is doing field work with the Cape Breton Island Public Health Unit following her course in public health administration at McGill University. Each member was presented with a gift at the tea in honor of the 1948 class, given by Dr. and Mrs. A. Gaum. Each nurse also received a gift from the Senior Ladies Auxiliary of the hospital.

ONTARIO

District 1

LONDON:

Victoria Hospital:

National Hospital Day was marked at Victoria Hospital by a celebration that took the form of an alumnae banquet, symbolizing the sixty-five year record of the hospital school of nursing. Thirteen older graduates received life memberships in the alumnae association at this time. The special banquet speaker was Marjorie Rutherford, a graduate of 1932 who served overseas during World War II. Miss Rutherford said, "The foresight and planning of the first board of trustees has been justified." She recalled that the school had been organized in 1883 under Sister Florence of the Order of St. John of Jerusalem. It gave a two-year course. Prospective nurses had to pass examinations in reading aloud, writing legibly, keeping simple accounts, and taking notes. In 1883 there were three graduates, in 1948 fifty-eight, making a grand total of 1,751.

Receiving life memberships were the following: Patricia Murray (1898), Elizabeth McCutcheon (1899), Mrs. Bleenie Wilson (1903), Florence Waugh (1907), Mrs. Ethel MacDonald (1905), Mrs. Margaret Patterson (1906), Ida Bull (1912), Ethel Stephens, Lily McGugan (1921), Agnes Malloch (1918), Hilda Stuart.

Districts 2 & 3

Over one hundred members were present at a general meeting of Districts 2 and 3 held at the Kitchener-Waterloo Hospital, with the chairman, Margaret Grieve, presiding. Reports of the various sections were read and matters of business attended to. An interesting and instructive address on "Fractures" was given by Dr. Alister Lackuer. His lecture was illustrated by x-ray and with the patient present, showing the newer methods of treatment. Florence Walker, associate secretary, R.N.A.O., was present and led in a discussion on the benefits of the Nurses' Practice Act. Tribute was paid to Matilda Fitzgerald, retiring secretary-treasurer of the provincial association. Miss Friesen delighted the audience with vocal solos.

There was a discussion on the shortage of nurses, with plans for an extensive recruiting campaign. Several service clubs have offered bursaries and more are to be contacted in this regard. A delightful dinner was served by the hospital alumnae when Mr. W. Cowles entertained the group with an address on "The Importance of a Sense of Humor."

Good wishes were extended to Miss Scott, superintendent of the Kitchener-Waterloo Hospital, who is retiring.

BRANTFORD:

There was a large attendance at the annual banquet meeting held by the Brantford General Hospital Alumnae Association. The guest speaker, introduced by Marion Patterson, convener for the occasion, was Mr. Marshall Close of Toronto, who is associated with the C. W. Wright public speaking course. In his address on Canada, Mr. Close gave a brief outline of the status of Canada in the world today. He emphasized the many opportunities and privileges which we as citizens of a democratic country enjoy, and the dangers of taking too much for granted. Laura Burtch thanked the speaker.

The draw for the blanket, which was donated to the alumnae association by a local firm, proved an interesting highlight at the annual doctors' dance. Mrs. Mary Jackson was the lucky winner.

Mr. Harold McConechy was the guest speaker at a recent alumnae meeting when he gave an informative talk on his South American tour. He illustrated his address with colored films.

A successful concert, sponsored by the alumnae association, was held at the Collegiate Institute when Sheila Munro, pianist, and Jean McLeod, contralto, were featured artists. A reception was held following the concert. The proceeds will go toward scholarship and charitable purposes.

Those who served on the banquet and dance committees, in honor of the class of 1948, were: M. Patterson and J. Landreth (conveners), M. Cockburn, B. Jull, Mrs. L. Sheppard, A. Attlebury, T. Kett, Mrs. D. Habberjam.

DISTRICT 4

NIAGARA FALLS:

One of the most largely attended meetings of Niagara Peninsula Chapter was held recently at the Greater Niagara General Hospital. The chairman, Catharine O'Farrell, presided and introduced the guest speaker, Dr. E. Janes, M.B., of the McGregor Clinic, Hamilton, who gave an informative address on "Modern Treatment of Surgery," outlining the new types of surgery that have been developed. He revealed that the mortality in every branch of surgery has decreased appreciably in recent years. Dorothy Sharpe, executive member, thanked the speaker.

A social hour followed with Mrs. H. Jolley, rendering several solos accompanied by Mrs. E. Parker at the piano. Alex Read entertained and was thanked by the secretary, Eleanor Smith. A film, showing the visit of "Canada's Future Queen," was enjoyed through the courtesy of George Hamilton, B.A., and M. Stevens of the Niagara Falls Collegiate. The superintendent, Ruby Thompson, and her staff were thanked, also Mrs. B. Bowden who was convener of the buffet lunch and her committee—Mmes M. Henderson, V. Wilson, Crawford, C. Dick, Neilson, and Misses Stirling, Rampado, Newton Smith, Tufts, M. and S. Flynn, Regant, and Mary Kiemele.

The chairman gave a detailed report of the

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McGILL UNIVERSITY, MONTREAL 25

R.N.A.O. convention, emphasizing the importance of the Nurses' Practice Act.

District 5

TORONTO:

The Royal York Hotel was the scene of the well-attended meeting and banquet of District 5 when the afternoon session was addressed by Mrs. Alice French whose topic was "Guaranteed Life Income." At the evening banquet Dr. Charlotte Whitton, C.B.E., addressed the members, when her subject was "Nursing in a Changing Social Structure."

St. Joseph's Hospital:

Award winners at the annual graduation exercises included the following: Proficiency in obstetrical nursing, Florence Mortimer; proficiency in prophylactic nursing, Myrtle Lane; Dr. Vincent McDonough memorial prizes for general proficiency, Frances Tapp, Edith McDonald, Margaret Sullivan.

Toronto East General & Orthopedic Hospital:

At the May Tea, sponsored by the alumnae association, a cheque was presented to the Hospital Board, by Mrs. G. Seelig, alumnae president, in aid of the hospital building fund. This year the alumnae is presenting a bursary to a member of the graduating class who desires to further her nursing education. The nurse must apply to the alumnae, stating the course she wishes to take, and the recipient will be chosen by the Bursary Committee.

District 6

PETERBOROUGH:

The members of Chapter C felt very fortunate in having present at a recent regular meeting, Mary Millman, convener of the Legislation Committee, R.N.A.O. A. L. Thomson, chairman, was in charge of the proceedings with thirty-six present. Miss Millman reviewed the Ontario Nurses' Act and answered questions concerning its various points. She stressed the importance of publicizing the Act at women's organizations in the city and the necessity of familiarizing the candidates for Parliament from the local ridings with the purposes and value of the Act.

The social part of the meeting took the form of a farewell party for one of the chapter's valued members, Lois Stewart, who is leaving for British Columbia. She was presented with a shower of gaily-wrapped handkerchiefs suspended from a colorful parasol. Musical selections were supplied by "The Novelty Boys" followed by bingo. The program was under the direction of Mrs. M. Moore and Mary Murphy. K. Dorris was in charge of lunch.

District 7

BROCKVILLE:

The Brockville Chapter recently sponsored a bridge, the proceeds of which were used to send members to the C.N.A. convention in Sackville, N.B. The Comstock Memorial

Nurses Home at the General Hospital was the scene of this event when over two hundred guests assembled and enjoyed the hospitality of the district nurses. M. G. Purcell, superintendent of the General Hospital, and Mrs. Orr, superintendent of the Ontario Hospital, were chosen to represent the chapter at the convention.

At a recent meeting four letters were read from Scottish nurses who had received food parcels from the chapter.

The annual Vesper Service was held at the beginning of May at St. John's United Church with the Rev. P. C. Lewis delivering a very stimulating sermon, entitled "Memory." Nurses were in attendance from the two hospital staffs.

KINGSTON:

Ontario Hospital:

The following officers will serve the alumnae association during the coming months: President, J. Smeathers; secretary, N. McElheran; treasurer, Mrs. D. Ferguson; vice-presidents, Mmes Greenwood, C. White; committee conveners: social, F. Mills; visiting, Mrs. Pomeroy; honorary members, Sr. M. Assumption, Mrs. J. Pratten.

Dr. Orm. Green, at a meeting of the alumnae, spoke on the importance and growth of x-ray during the last fifty years. One meeting took the form of a social evening, each member bringing a friend, when prizes were given for euchre and bridge. At the May meeting a technicolor film was shown of the Gatineau. An interesting report was given by the president on the R.N.A.O. convention.

DISTRICT 8

Ottawa Civic Hospital:

There was a large attendance at the annual spring tea held by the alumnae association. E. G. Young and P. Farmer received the guests. Old friendships were renewed as many former graduates from Ottawa and district attended with their children. The conveners for this event were E. Horsey, R. Seeley, M. Cowie, and M. Simpson. Presiding at the tea table were the following past presidents: Mmes G. Dunning and D. Ball, Misses I. Dickson, L. Gourlay, and M. Downey, assisted by Mmes I. Veitch and E. Storr, Misses F. Garnett, D. Hillis, A. Napier, M. Anderson, and K. Conley.

Ottawa General Hospital:

On the first Sunday in May, memorial services were held in the chapel of the Mother House of the Grey Nuns of the Cross in memory of the nurses who died in the two World Wars. The Rev. Father Emile Vézina, padre of the Régiment de Hull, and at present chaplain of St. Vincent's Hospital for Incurables, Ottawa, officiated. There was a large attendance of graduate and student nurses. After the services, the group gathered at the nurses' residence where an Honor Roll, bearing the names of the thirty-six nurses who served in World War I, was unveiled.

DERMATOLOGY FOR NURSES

By K. A. Baird. Written by a specialist to remedy the relative neglect of this subject, and to simplify for nurses the complicated material now available. "Attractively written and will be of undoubted help to nurses in training."—**Canadian Medical Association Journal.** 83 pages. 11 full-page illustrations. 1947. $2.00.

LAW AND THE PRACTICE OF NURSING

By Nettie D. Fidler, in collaboration with Kenneth G. Gray. To safeguard her position, every practising nurse should be familiar with the information in this book. A copy would prove invaluable for reference in every medical and nursing library. $2.00.

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An examination for the title and certificate of Registered Nurse of British Columbia will be held on September 14, 15, and 16, 1948.

Names of candidates for this examination must be in the office of the Association not later than August 14, 1948.

Full particulars may be obtained from:

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Ottawa.

Rev. Sr. Marie Alban, superior of the hospital, and a member of the class of 1923, recently celebrated her Silver Jubilee and was presented with a suitable gift from the alumnae members. Two Sisters of the Order of the Grey Nuns of the Cross — Rev. Sr. Alice de Marie, mother assistant of the Order, and Rev. Sr. Ernest — recently visited Rev. Sr. Veronica who is in charge of the isolated mission hospital at Spirit River, Alta. This hospital is the farthest mission hospital operated by the Grey Nuns in Canada. Thérèse Charlebois has been appointed to the staff of nurses employed by the Department of National Health and Welfare.

QUEBEC

MONTREAL:

Children's Memorial Hospital:

A most successful social evening and raffle was sponsored by the social committee which enabled Marion Cochran to represent the Staff Association at the C.N.A. biennial convention.

The staff regrets the resignation of Marion Collins who has been on the staff for the past fifteen years. She will be keenly missed by her associates. E. Collins has returned as head nurse, Ward L, after eight months' leave of absence. Recent appointments include: Laura Gray, Helen MacLean, Jean Thirlaway, Helen Jackman.

Homoeopathic Hospital:

Two sisters from St. John's, Newfoundland, were the major prize winners of this year's graduation class of the Phillips School of Nursing. They are Jane and Joan Clouston, the former being awarded a prize donated by the Griffith family for general proficiency, while the latter received the medical staff's prize for highest standing in theory.

Other prize winners in the class of nineteen girls were: Evelyn Hughes, bedside nursing prize; Helen Simon, the Dr. G. T. Novinger prize for surgical nursing. Marie Soga, a member of next year's class, was presented with the prize of the nursing school instructors for general proficiency in the intermediate class. Jane Clouston also received the alumnae association prize.

In a brief welcome, Douglas Bremner, president of the Board of Management of the hospital, stressed the importance of the nursing profession in a "community which is becoming more health conscious every day."

Dr. W. G. Cullen, of the hospital's medical staff, in an address to the graduates reminded them to always keep their minds open to new ideas, methods, and treatments, particularly in view of the fact that "it is often more difficult to unlearn than to learn."

The main speaker of the evening was Rev. Norman A. MacMurray who discussed the place of prayer and religion in a hospital. The invocation was said by Canon R. K. Naylor and Mrs. A. R. Griffith presented the graduates with their diplomas. Mrs. E. D. John-

son, president of the hospital's Women's Auxiliary, gave them their medals which were pinned to their uniforms by Miss M. G. Russell, director of nursing.

Montreal General Hospital:

Seventy-two graduates received their medals and diplomas from Major S. C. Norsworthy, D.S.O., M.C., president of the hospital, at the recent graduation exercises. The address to the new graduates, entitled "The Evolution of the Nurse," was given by Dr. Edward S. Mills, chairman of the hospital's Department of Medicine and professor of medicine at McGill University.

The prize winners, who were presented with their awards by Lt. Col. W. Leggat, O.B.E., M.C., chairman of the Nursing Services Committee, were announced by Mary Mathewson, director of nursing. They were: Dr. H. A. Lafleur Reporting Society prize for highest standing in medical nursing, Margaret Hanna; Jennie Webster prize for highest aggregate standing in special services during three-year course, Mabel Hiscock; Dr. A. D. Campbell prize for highest standing in special exam in gynecological and obstetrical nursing, Wanda Patterson; Mildred Hope Forbes prizes for highest aggregate marks during three-year course, Ileana Norman, Jean M. Ellis; Board of Management prizes for general proficiency, Elizabeth Chalmers, Mary Bradley, Caroline Hall; Department of Dermatology prize for proficiency in dermatological nursing, Edna Biard.

Royal Victoria Hospital:

A fashion show, presented through the courtesy of The T. Eaton Co. Ltd., under the direction of Doreen Day, was the highlight of the dinner given by the alumnae association in honor of the class of 1948. The prize awards were announced by Fanny Munroe, superintendent of nurses. Dorothy Riches, R.R.C., a member of the class of 1932, and director of the school of nursing, Queen's University, Kingston, proposed the toast to the graduating class. In addition to the pride felt at the attendance of seventy-eight members of the graduating class it was the memorable occasion of the twenty-fifth anniversary of the class of 1923 and thirty-eight members were able to be present. Mrs. George D. (Kirkpatrick) Floyd (1920) and Mrs. M. E. (Mills) Steele (1919) also attended the dinner.

A fully equipped central supply room has been opened in the Ross Pavilion under the capable direction of Mrs. K. (Glynn) Cherry.

Joyce Northcote has resigned to be married and E. Carson has accepted the position of assistant head nurse on Wards G. and H. J. Patterson has resigned to go to England and Mrs. K. Duncan will take charge of Ward F. Doris Sheppard has also resigned to be married and H. MacIntyre is now assistant head nurse on Ross 3. E. O. Neill is in charge of Ward M.

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pital, New York, called at the school recently. She reported that Jacqueline Foster and Margaret MacKay are also on the staff of that hospital.

SASKATCHEWAN

Dr. A. E. Buckwold, who recently returned from study in England, was guest speaker at a meeting of the S.R.N.A. Dr. Buckwold told of his experience in the old country.

REGINA:

At the final meeting for this season of Regina Chapter it was decided each of the standing committees would be responsible for the program at the meetings next season. Eleven members were present at the last meeting of the season of the chapter's Public Health Section.

Carmichael United Church was the scene of the Vesper Service, when there was in attendance a uniformed representation of both students and graduates from the General and Grey Nuns' Hospitals.

Elizabeth Smith, director of nursing services for Saskatchewan, attended the Canadian Public Health Association convention held in Vancouver. Lillian Domes has joined the city public health nursing staff.

The following nurses are now employed in the newly-opened Medical Arts Clinic: Misses Belle Walton (general supervisor), Pawson, Miller, McCusker, Skelton, Wenhardt, N. Brown, Schmidt, Jordon, Benson, P. Jones, Gange, A. McDonald, Payne, Poisson, Traynor, Hoffman, Mrs. J. (Antonini) MacDougall. Mrs. D. Weaver has resigned from the staff.

SASKATOON:

The annual memorial and rededication Vesper Service for nurses was held at Knox United Church when the speaker was Rev. D. Wilkie, whose address was entitled "Would Your Life Make a Good Story." About three hundred nurses, representing the V.O.N., the city public health nurses, the N.S.A., the D.V.A. hospital, the sanatorium, as well as both graduates and students from St. Paul's and City Hospitals, were in attendance.

St. Paul's Hospital:

Fifty-three graduates took part in the exercises of the school of nursing. Following graduation, a banquet and dance was sponsored by the first-year students for the parents of the graduating class. Each mother received a miniature sail-boat as a souvenir.

A new cook book, the work of St. Paul's Hospital Ladies Auxiliary, is available for the nominal cost of $1.00 each. The book is interesting and well compiled. The Ladies Auxiliary has been generous in contributions to the school of nursing, evidence of this being a post-graduate course for a member of the graduation class.

Nano Naglo, a member of the class of 1948, will enter the Precious Blood Sisters at London, Ont. M. Barth, D. Moore, K. Coflin, and L. Frey have returned from taking courses in obstetrics at Royal Victoria Hospital, Montreal. H. Reeves and L. Golden are leaving to be married. Dora Norris is gaining further experience in obstetrical work at the Brantford General Hospital prior to taking a post-graduate course.

SWIFT CURRENT:

A banquet was held by Swift Current Chapter in honor of eight Grade XII girls who are entering training this fall. The guest speaker was Mrs. G. Harrison, past provincial president.

Frances Russell and Edna Duscheno have entered training for stewardesses with the T.C.A.

YORKTON:

On Hospital Day the Yorkton General Hospital Alumnae Association served tea in the nurses' residence. The alumnae's home-cooking sale proved successful, the proceeds helping to send a 1948 graduate to the C.N.A. biennial convention.

Positions Vacant

Associate Director of Nursing Service & Director of Educational Program. Gross minimum: $3,000. Rental of suite in attractive surroundings. Sitting-room. Bedroom and bathroom available at very reasonable rental. Meals in hospital available at nominal rates. **Associate Dietitian-in-Charge.** Gross minimum: $2,400. Full maintenance available at nominal charge $36 per month. Apply, giving full information, academic, professional, and personal, in preliminary application, to Supt., General Hospital, Kingston, Ont.

Nursing Arts & Science Instructor for 115-bed hospital. Position on or before Aug. 1. Living accommodation if desired. State salary in 1st letter. Apply, stating qualifications, to Supt. of Nurses, Victoria Hospital, Winnipeg, Man.

Clinical Instructor for School of Nursing. 140-bed General Hospital in very central location. Position open July 1. Apply, stating full particulars, education, experience, etc., to Director of Nurses, Herbert Reddy Memorial Hospital, 4039 Tupper St., Montreal 6, Que.

Health Instructor & Supervisor with Public Health course and experience, **Supervisor for Isolation Dept., General Staff Nurses** for General Hospital, Regina, Sask. Apply, stating qualifications, experience, salary expected, to Supt. of Nurses.

Supervisor for Clinical Teaching in 125-bed hospital. **Head Nurse** for 20-bed ward. 8-hr. day, 6-day wk. 1 month vacation with pay after a yr. Apply, stating qualifications, salary expected, to Supt. of Nurses, Children's Hospital, Winnipeg, Man.

Operating-Room Supervisor with post-graduate training & experience preferred. Apply, stating experience, salary expected, to Director of Nursing, Yarmouth Hospital, Yarmouth North, N.S.

Operating Scrub Nurse. General Duty Nurses for Veterans' Floor in New Wing. Salary: $135 per month living out. Meals & laundry provided. Apply to Supt. of Nurses, General Hospital, Port Arthur, Ont.

Night Supervisor & Graduate Staff Nurses for 30-bed General Hospital 50 miles north of Toronto. Attractive resident facilities available if desired. Apply, stating qualifications, to M. McComb, Supt., Lord Dufferin Hospital, Orangeville, Ont.

Public Health Nurse (qualified) for general program in urban centre of 27,000. Starting salary: $1,800-$2,100 dependent upon experience. 5-day wk. 9:00 a.m.-5:00 p.m. Lunch 1½ hrs. Employment benefits include: Pension Plan, sick leave, 3 wks.' vacation. Apply to Mr. Norman T. Dawe, Personnel Officer, Westmount City Hall, 4333 Sherbrooke St. W., Montreal 6, Que.

Registered Nurses for Pediatric-Orthopedic Hospital. 8-hr. day, 6-day wk. Full maintenance or live out as desired. For further particulars apply to Supt., Shriners' Hospitals for Crippled Children, Montreal Unit, Que.

Graduate Nurses (2) for General Duty at General Hospital, Salmon Arm, B.C., on the shore of Shuswap Lake, North Okanagan District. 40-bed hospital, 6-day wk. Straight 8-hour shift. Beginning salary: $140 per month with annual increase. Deduction $25 per month for full maintenance & laundry. Full month's vacation with pay after 1 yr.'s service. Up to $25 fare refunded after 6 months' service. Accumulative sick leave & all legal holidays allowed. Apply Matron.

Registered Nurses for General Staff at Tranquille Sanatorium, situated on Kamloops Lake near Kamloops, B.C. Gross salary for 8-hr. day, 5½-day wk.: $174 per month during 1st yr., $186 per month for 2nd yr. & $5.00 raise per month in 3rd, 4th, and 5th yrs. of service, minus $27.50 for board, room, laundry. 31 days' vacation per annum with pay plus 11 days statutory holidays. 14 days sick leave each yr. accumulative with pay plus 6 days incidental illness. Superannuation Plan. Up to $50 of fare refunded. Apply to Supt. of Nurses, Tranquille, B.C.

Graduate Nurses for 124-bed hospital in beautiful Kootenay Lake District in British Columbia. Ideal summer resort. Salary: $140 gross per month. Apply to Supt. of Nurses, Kootenay Lake General Hospital, Nelson, B.C.

Registered Floor Duty Nurses for small hospital in modern community. Salary: $145 with full maintenance. 8-hr. duty rotating. 6-day wk. 3 wks.' vacation with pay per yr. Sickness insurance. Retiring plan. Apply Boisvert Memorial Hospital, Baie Comeau, Que.

Registered Nurses (2) for General Duty. 44-hour week. Apply for further information to Supt. of Nurses, Mountain Sanatorium, Hamilton, Ont.

Registered General Duty Nurses. Salary: $159.50 monthly less perquisites $33. Salary paid bi-weekly. Salaries have scheduled rate of increase. Cumulative sick leave. Pension Plan. Blue Cross. 3 wks.' holiday after yr. of service. Apply to Mrs. M. McGee, Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Qualified Registered Nurse as Instructor. 150-bed hospital. Duties to commence Sept. Salary: $150 per month plus $30 maintenance. Apply, stating qualifications, experience, age, religion, to Supt. of Nurses, General Hospital, Chatham, Ont.

Operating-Room Nurses and General Staff Nurses. 44-hour wk. Starting salaries: $150 and $140 gross respectively. Registration in British Columbia essential. Apply Supt. of Nurses, Royal Columbian Hospital, New Westminster, B.C.

Assistant Superintendent. Salary: $140 per month with room and board. Apply Supt., General Hospital, Kenora, Ont.

Operating-Room Supervisor. Salary: $120 per month with room and board. Apply Supt., General Hospital, Kenora, Ont.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, Kingston, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock, and Toronto Psychiatric Hospital. Initial salary: $1,840 per annum, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 weeks' vacation, statutory holidays and special holidays with pay. 8-hr. day, 6-day wk. Apply to Supt. of Nurses at above hospitals.

Classroom Instructor for 100-bed hospital. Apply, stating qualifications and when services available, to Supt. of Nurses, Sherbrooke Hospital, Sherbrooke, Que.

Staff Nurse for Welland and District Health Unit. Duties to commence as early as possible. Urban area; transportation is supplied. Apply, stating experience, to Dr. L. W. C. Sturgeon. 120 King St., Welland, Ont.

Graduate Nurse for **General Staff Duty** for 350-bed Tuberculosis Hospital. Starting salary: $110 per month plus full maintenance. Apply to Miss C. Louise Bartsch, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

General Staff Nurses. 44-hour week. Gross salary: $155 plus laundry, with increases. Extra $5.00 all night rotation shifts. All perquisites. Registration in British Columbia essential. Apply to Director of Nursing, Vancouver General Hospital, Vancouver, B.C.

Graduate, Registered Nurse for Floor Duty. Salary: $100 per month; full maintenance; increase of $5.00 per month after 1 year's service, up to 3 years. 8-hour duty. Blue Cross Hospitalization. Apply to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

Qualified Dietitian for General Hospital. Good salary and full maintenance. Apply to Administrator, General & Marine Hospital, Owen Sound, Ont.

Graduate Nurses with Public Health Certificates for Nursing Service in Public and Secondary Schools. Apply, giving qualifications, experience, age, and other particulars, to Miss Mollie Towers, Sec., Board of Education, Sault Ste. Marie, Ont.

General Duty Nurses. Salary: $120 per month. 8-hour day. 6-day week. Full maintenance. For further particulars apply Supt., Municipal Hospital, Vulcan, Alta.

Instructor of Nurses for 188-bed General Hospital in Southern Alberta. Duties to commence Aug. 1 or 15. Apply, stating age, qualifications, experience, to Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Instructor for 285-bed hospital. Gross salary: $190. 8-hr. day, 6-day wk. 1 month's vacation with pay annually. Apply, stating experience, qualifications, to Supt. of Nurses, McKellar Hospital, Fort William, Ont.

Residence Nurse by Sept. 1 for University of Toronto School of Nursing. Public Health training preferred. Apply now to Secretary of School.

Instructor of Nurses, Operating-Room Nurse, General Staff Nurses. Liberal salaries. Excellent living conditions with recreational facilities. 1 month annual vacation. 5-day week. Apply Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, Que.

Registered Nurses (2) for Operating-Room. General Duty Nurses. Salary: $110 per month plus full maintenance. Apply Director of Nursing, General Hospital, Welland, Ont.

Operating-Room Supervisor (qualified). 120-bed hospital with training school. New hospital in process of design. Apply, for exchange of full particulars, Supt. of Nurses, Galt Hospital, Lethbridge, Alta.

General Duty Nurses for new 26-bed hospital. Salary: $120 per month with full maintenance. Increased $5.00 after 6 months. Straight 8-hr. 6-day wk. **Permanent Night Nurse.** 3 wks' holiday with pay after 1 year's service. Situated on C.P.R. line 50 miles north of Calgary. Excellent train & bus service. Apply Miss M. A. MacDonald, Matron, Municipal Hospital, Didsbury, Alta.

Matron for 30-bed hospital located in Southern Interior of B.C. near U.S. border. 2 active surgeons on staff. Gross salary: $160 per month; maintenance $20 per month. 4 wks' vacation with pay plus 9 statutory holidays. Generous recreational facilities; also popular summer resort nearby. Apply Mr. A. Rutherford, Sec. Mgr., Community Hospital, Grand Forks, B.C.

General Duty Nurses for 30-bed hospital situated in Southern Interior of B.C. Gross salary: $140 per month; maintenance $20 per month. 8-hr. duty. 4 wks.' vacation with pay per yr. plus 9 statutory holidays. Apply Mr. A. Rutherford, Sec. Mgr., Community Hospital, Grand Forks, B.C.

General Duty Nurses (2) by Sept. or sooner. 25-bed United Church hospital on Pacific Coast. 5 wks' annual holiday. Transportation allowance. Apply General Hospital, Bella Coola, B.C.

General Duty Nurses. Salary: $100 with room and board. Apply Supt., General Hospital, Kenora, Ont.

Night Supervisor for 80-bed General Hospital. Salary: $145 plus maintenance, hospitalization, sick leave. Apply, stating qualifications, date available, to Supt., Norfolk General Hospital, Simcoe, Ont.

Supervisor for Communicable Diseases Unit, Supervisor for Pediatric Dept., Head Nurse for Operating-Room for Civic Hospital, Ottawa, Ont. Apply, stating age, qualifications, experience, salary expected, to E. G. Young, Director of Nursing.

Graduate Nurses for Operating-Room (post-graduate course desirable or considerable experience). Salary: $137.33 a month plus meal & laundry. Living out. Increase of $5.00 after 3 months if post-graduate, otherwise after 6 months. For full information write Director, Nursing Service, Victoria Hospital, London, Ont., giving full particulars as to graduation, experience, references, when available for duty.

Supervisor of Nurses for School Division of Calgary City Health Dept. Administration & Public Health training essential. Apply, giving qualifications, experience, age, references, other particulars, to Medical Officer of Health, City of Calgary, Alta.

Cool Comfort

This summer Canadians again face the need of guarding against heat sickness. When a person is exposed to very high temperatures, such as are found in some industries, and fails to take the necessary precautions, he may experience dizziness, headache, cramps, and nausea.

These are the first signs of impending heat sickness and indicate that the regulatory mechanisms for controlling the body temperature are unable to cope with the situation. Immediate action should be taken to remove the patient to a cool, airy place, and to summon a doctor.

For a Healthy, Happy Holiday

If you are a non-swimmer avoid deep water and stay out of a canoe! Don't go in the water immediately after eating!

Learn about artificial respiration . . . you may save somebody's life!

Take the sun in easy doses — sunburn is a real burn!

Learn what poison ivy looks like — then avoid it!

Be sure your water supply is pure!

Make certain your vacation milk supply is pasteurized — if not, pasteurize it yourself!

Avoid over-exertion, particularly if you are unaccustomed to strenuous exercise!

In hot weather use more salt in your diet!

Subtlety, some sages say, is the art of saying what you want to say and then getting out of range before it is understood.

Official Directory

CANADIAN NURSES' ASSOCIATION

1411 Crescent St., Montreal 25, P.Q.

President..... Miss Rae Chittick, Faculty of Education, University of Alberta, Calgary, Alta.
Past President..... Miss Fanny Munroe, Royal Victoria Hospital, Montreal 2, P.Q.
First Vice-President..... Miss Ethel Cryderman, V.O.N., 281 Sherbourne St., Toronto 2, Ont.
Second Vice-President... Miss Evelyn Mallory, University of British Columbia, Vancouver, B.C.
Third Vice-President..... Miss Marion Myers, Saint John General Hospital, Saint John, N.B.
Honorary Secretary..... Rev. Sister Denise Lefebvre, 1185 St. Matthew St., Montreal 25, P.Q.
Honorary Treasurer..... Miss Lillian Pettigrew, 214 Balmoral St., Winnipeg, Man.

COUNCILLORS AND OTHER MEMBERS OF EXECUTIVE COMMITTEE

Numerals indicate office held: (1) *President, Provincial Nurses Association;* (2) *Chairman, Committee on Institutional Nursing;* (3) *Chairman, Committee on Public Health Nursing;* (4) *Chairman, Committee on Private Duty Nursing.*

Alberta: (1) Miss B. Emerson, 23 Rene LeMarchand Mansions, Edmonton; (2) Miss A. Anderson, Royal Alexandra Hospital, Edmonton; (3) Miss G. Hutchings, Strathmore; (4) Miss Orma Smith, Galt Hospital, Lethbridge.

British Columbia: (1) Miss E. Mallory, University of B.C., Vancouver; (2) Miss E. Davis, Ste. 22, 1311 Beach Ave., Vancouver; (3) Miss A. Beattie, 1325 W. 12th Ave., Vancouver; (4) Miss K. MacKenzie, 1584 W. 13th Ave., Vancouver.

Manitoba: (1) Miss I. Barton, Veterans' Home, Winnipeg; (2) Miss F. Philo, Children's Hospital, Winnipeg; (3) Miss T. Greville, 419 Borebank St., Winnipeg; (4) Miss M. Muir, 16 Gordon Apts., Winnipeg.

New Brunswick: (1) Miss M. Myers, Saint John General Hospital; (2) Sr. M. Rosarie, St. Joseph's Hospital, Saint John; (3) Miss M. Clark, 285 Germain St., Saint John; (4) Mrs. B. Nash Smith, 57 Queen St., Moncton.

Nova Scotia: (1) Miss L. Grady, Halifax Infirmary; (2) Miss R. MacDonald, Aberdeen Hospital, New Glasgow; (3) Miss M. Shore, 314 Roy Bldg., Halifax; (4) Mrs. D. Luscombe, 364 Spring Garden Rd., Halifax.

Ontario: (1) Miss N. D. Fidler, 849 Kildare Rd., Windsor; (2) Miss C. Tavener, 42 Isabella St., Toronto 5; (3) Miss S. Wallace, Dept. of Health, Parliament Bldgs., Toronto 2; (4) Miss D. Marcellus, 166 Roxborough St. E., Toronto 5.

Prince Edward Island: (1) Mrs. L. MacDonald, P.E.I. Hospital, Charlottetown; (2) Miss K. MacLennan, Provincial Sanatorium, Charlottetown; (3) Miss E. Wheler, Public Health Dept., Summerside; (4) Mrs. M. Storey, 91 Fitzroy St., Charlottetown.

Quebec: (1) Rev. Soeur Valérie de la Sagesse, I.E., Hôpital Ste-Justine, Montreal 10; (2) Miss C. Lynch, Allan Memorial Institute, 1025 Pine Ave. W., Montreal 2; (3) Miss H. Perry, 4814 Fulton Ave., Montreal 26, (4) Mlle A. M. Robert, 3677 rue Ste-Famille, Montréal 18.

Saskatchewan: (1) Miss E. James, Regina General Hospital; (2) Miss S. Leeper, 130-8th St. E., Saskatoon; (3) Miss G. McDonald, No. 5, 2025 Lorne St., Regina; (4) Mrs. M. Robertson, 120 Ave. I North, Saskatoon.

Religious Sisters: Rev. Sr. Columkille, St. Paul's Hospital, Vancouver, B.C.; Rev. Sr. M. Kathleen, St. Michael's Hospital, Toronto 2, Ont.; Rev. Sr. St. Gertrude, Civic Hospital, 1051 Chemin de la Canardière, Quebec, P.Q.; Rev. Sr. M. Irene, Holy Family School of Nursing 15th St. W., Prince Albert, Sask.

CHAIRMEN OF NATIONAL COMMITTEES

Committee on Constitution and By-Laws: Miss Eileen Flanagan, 3801 University St., Montreal 2, P.Q.
Committee on Educational Policy: Miss Agnes Macleod, Dept. of Veterans' Affairs, Ottawa, Ont.
Committee on Institutional Nursing: Rev. Sister Delia Clermont, St. Boniface Hospital, Man.
Committee on Labor Relations: Miss E. K. Connor, Central Alberta Sanatorium, Calgary, Alta.
Committee on Private Duty Nursing: Miss Barbara Key, 123 Bold St., Apt. 56, Hamilton, Ont.
Committee on Public Health Nursing: Miss Helen McArthur, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ont.

EXECUTIVE OFFICERS

International Council of Nurses: 19 Queen's Gate, London S.W. 7, England. Executive Secretary, Miss Daisy C. Bridges.

Canadian Nurses' Association: 1411 Crescent St., Montreal 25, P.Q. General Secretary, Miss Gertrude M. Hall. Assistant Secretary, Miss Winnifred Cooke.

PROVINCIAL EXECUTIVE OFFICERS

Alberta Ass'n of Registered Nurses: Miss E. Bell Rogers, Revillon Bldg., 104th St., Edmonton.
Registered Nurses' Ass'n of British Columbia: Miss Alice L. Wright, 1014 Vancouver Block, Vancouver.
Manitoba Ass'n of Registered Nurses: Miss Lillian Pettigrew, 214 Balmoral St., Winnipeg.
New Brunswick Ass'n of Registered Nurses: Miss Alma F. Law, 29 Wellington Row, Saint John.
Registered Nurses' Ass'n of Nova Scotia: Miss Nancy Watson, 301 Barrington St., Halifax.
Registered Nurses Ass'n of Ontario: Miss Matilda E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 5.
Prince Edward Island Registered Nurses' Ass'n: Miss Helen Arsenault, Provincial Sanatorium, Charlottetown.
Association of Nurses of the Province of Quebec: Miss E. Frances Upton, 506 Medical Arts Bldg., Montreal 25.
Saskatchewan Registered Nurses' Ass'n: Miss Kathleen W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.